











# THE CANADIAN NURSE

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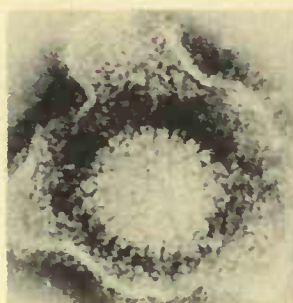
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*The Canadian Nurse* welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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# perspective

It is November. The streets of Montreal are beginning to fill with homeward bound commuters as I leave them behind. As the bus hisses through the rain along the four lane highway linking Montreal to Ottawa, lights from farms along the way shine out of the dark.

The meeting I have just left is the fourth provincial annual meeting that I have attended in the past six months. I am thinking about the comment of the nurse who sat beside me at today's luncheon and remarked on how lucky I was to have the chance to visit all of these different provinces. I think of meetings over the last five years in Toronto, in Vancouver, in Regina, in Winnipeg, in Edmonton, in St. John's — from Kelowna, B.C. to Bridgewater, N.S.



I think of the nurses I have met and talked with at these meetings — nurses who care about their profession, care about their colleagues, nurses who are willing to give up some of their precious free

time to work for goals as intangible and elusive as the ones their professional associations have adopted. These are nurses working with other nurses to promote higher standards of nursing practice so that people in this country can have better nursing care. Nurses whose aim it is to make sure that the educational programs available to nursing students and to graduates who want to add to their skills and knowledge are the best that can be offered. Nurses who are trying to find ways of helping other nurses to understand, support and encourage each other. Nurses who are willing to speak out on behalf of their colleagues at all kinds of meetings here in this country and abroad.

I think of the nurses at the national and provincial level

who put these goals ahead of personal needs and desires so that they can run for office. I think of the members of boards and committees who ask questions, read, study and travel in order to make a success of their particular project. I think of members who turn out faithfully for chapter meetings on nights when the roads are bad or they are tired after a particularly demanding shift.

I realize that these nurses are unusual: commitment at this level is a rare and special thing. And I think, yes, I am lucky to have the chance to get to know these nurses. And, what is more important, their colleagues and their clients are lucky that nurses like these exist and that they still care.

Photo by Studio Impact

M.A.B.

## herein

**Collaboration** is the lifeblood of every magazine. This is particularly the case when that journal is intended to reflect what is going on in a profession like nursing.

These days, most of the manuscripts that cross the editor's desk bear the hallmarks, not just of good intentions, but also of creative and innovative thinking, conscientious effort and considerable skill and ingenuity in putting it all together.

Nurses are using the written word to share their experiences with their colleagues. This sharing does not always have to be confined to words, however. Are you an amateur photographer looking for a new vehicle to display your talents? Are you a nurse whose most exciting camera

shots are ones that emphasize the caring aspect of health care?

If so, we'd like to see some samples of your work, with a view to sharing with other nurses the moments you've captured. The Canadian Nurse is looking for high quality color negatives or prints that might be featured on the cover, as well as good black and white prints for possible inside illustrations. Enquiries should be directed to The Editor, The Canadian Nurse, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

### Did you know...

There are 10 hospitals in Canada that have incorporated Friesen concepts in their designs. Gordon Friesen, a London, Ontario health consultant, believes hospitals should be 'supermarkets' of health, and emphasize preventive care first, curative care second. One hundred and fifty hospitals around the world have used some of Friesen's ideas, one of which is that doctors' offices should always be inside a hospital to save duplication of health records and doctors' travelling time.

**If Winter comes, can Spring be far behind?** Maybe your reflections about the weather outside, the state of the economy or your attempts to finance a trip to warmer climes, leave you somewhat depressed. Well, cheer up, CNJ has some goodies in store for you that can't help but make 1980 a better year.

For starters, flip through this January issue to find out what's new and exciting on the education front. We've got news of the first ever national nursing education conference in Ottawa last November. We have some tips for nurses considering the job scene south of the border. And we've got a useful list of what's available at Canadian universities for RN's who want to upgrade their education credits.

Next month, you can look forward to a fine selection of clinical nursing articles on Legionnaire's Disease, Hypothermia, Psoriasis and Antidiuretic Hormone, among others.

Then, in March, help us celebrate CNJ's 75th anniversary — three score years and fifteen of providing Canadian nurses with the latest in nursing news.



In April, CNJ marches to the tune of the health enthusiasts with a special fitness and lifestyle issue. This one promises to be a collector's item: it's a lifestyle approach that's tailored to your unique needs and interests as a member of one of the health-giving professions — nursing. ♡



## Québec nurses pay tribute to children round the world

Choosing the central theme of a tribute to the International Year of the Child, the *Ordre des infirmières et infirmiers du Québec* held their annual meeting in Montréal last November. In an opening ceremony attended by some 1000 nurses, 80 Montréal schoolchildren, each carrying a flag representing the country of his national origin, were introduced to symbolize children everywhere. The guest of honor was Dr. Estafanis Aldaba-Lim, assistant secretary general of the UN and special representative for the Year of the Child.



With IYC nearly over, Dr. Lim focused her attention on the work that had been done during the past year but she emphasized that the spirit of IYC must not be allowed to die, the work must carry on.

She called upon the nurses of Canada to continue their role of commitment, cooperation and leadership to ensure the well-being of children.

Following Dr. Lim's speech, Nicole David, clinical nurse specialist in pediatrics at Maisonneuve-Rosemont Hospital, gave a presentation on one aspect of the nurse's role in the community, dealing with the problem of child abuse. She said that the problem is much larger than it appears: the awesome statistics of maltreated children represent only the cases that are reported, not the actual number. She said that nurses must examine closely the kind of parent model they are propagating in their practice. The nurse's role in the *prevention* of child abuse cannot be ignored either, she said; problems can be picked up even in prenatal classes and in the immediate perinatal period, as well as later in a child's life at home, in schools or clinics.

Two other presentations were of interest: Robert Gary, a specialist in Asian life, discussed the Chinese outlook on health care, and Michel Roy, editor of *Le Devoir*, spoke on the image of the nurse in the media.

### Resolutions

During the conference, Québec nursing delegates passed a vote to raise their membership fees by \$57, bringing the total fee for 1980 to \$147. Some delegates had promised their sections that they would not favor an increase, but they recognized that the OIIQ was in a difficult financial situation with an accumulated deficit of \$1,285,473.

Other proposals included the request that the Order's publication *Nursing Québec* take a more active role in providing information to members. Delegates asked too that the Order reinforce its liaison role, and apply pressure in the university setting to contribute to issues of nursing education. It was proposed also that the contribution of Québec nurses to the CNA be proportional to the number of nurses in other provinces.

### Attitudes

Of particular interest to many delegates was the presentation of a report by Secor Inc., commissioned by the OIIQ to research the Québec nurses' self image. A representative of the firm, a Montréal-based organizational consulting company, cautioned nurses against interpreting the report too negatively. The basic conclusion, after analyzing

the results of a mail questionnaire returned by 2157 Québec nurses, was that the level of professional satisfaction is quite high. If they had to do it over again, three out of five of the responding nurses said they would choose the same profession. More than two-thirds of the nurses said that they were satisfied with their jobs 70 per cent of the time, although the younger nursing graduates tended to be less satisfied. Less positive statements appeared when the nurses were asked about the perception of their role by the public and doctors. Fifty-two per cent of the respondents said that in practice, doctors didn't differentiate between RN's and auxiliary nurses. Further, as far as the average patient could see, nurses were nothing more than doctors' assistants, claimed 59 per cent of the nurses.

President Jeannine Tellier-Cormier made special note of the report's conclusion that nurses tended to be poorly informed and had difficulty getting away from their work to attend professional meetings; she said that the Order intends to undertake an in-depth study based on this important report.

The next annual meeting of the OIIQ will be held in Montréal, November 5 to 7, 1980.

## CNA MEMBERS AND ASSOCIATION MEMBERS

CNA members and association members are invited to **submit resolutions** for presentation at the Annual Meeting and Convention, June 1980.

Resolutions must be signed by a CNA member and forwarded to the Resolutions Committee, CNA House by **31 March 1980**.

Resolutions received **after 31 March 1980** cannot be presented to the annual meeting.





# CNA directors ready for 1980 Health Minister fields questions

A visit from Canada's Minister of Health to explain plans for the proposed National Health Care Institute and to answer questions from CNA directors about the current review of public health insurance plans in Canada was one of the highlights of the last regularly scheduled 1979 meeting of the Board of Directors of the Canadian Nurses Association.

Directors, too, were looking ahead, trying to determine the direction that growth and development within the nursing profession should take in the eighties. Based on their decisions at the October meeting at CNA House in Ottawa, nurses can anticipate action on their behalf this year on at least four fronts — all related, either directly or indirectly, to nursing education and to nursing practice.

## Getting going

The first of these, "Operation Bootstrap", is a short term funding proposal aimed at developing a nation-wide systematic plan for improving the basis of nursing practice in Canada. The project, which carries a price tag of just over \$5 million, calls for CNA to establish a seven-member Operation Bootstrap Committee consisting of representatives of CNA, the Canadian Nurses Foundation (CNF) and the Canadian Association of University Schools of Nursing (CAUSN).

The author of the preliminary report on Operation Bootstrap, Dr. Shirley M. Stinson, president-elect of CNA, explained to directors that the choice of name for the project was deliberate. "The nursing profession must itself take the initiative to 'get going' using whatever resources it can currently muster and within whatever constraints currently exist." The committee will be responsible for carrying out the preparatory phases of all five steps of the project:

- obtaining "starter grants" for establishing a PhD nursing program
- assisting interested institutions in obtaining initial funding for at least two nursing research centers
- obtaining funds to introduce a Communicating Nursing Research project
- creation of a reliable system for obtaining essential data on Canadian nurses with doctoral preparation, and
- setting up an emergency doctoral fellowship program.

The proposal is an outgrowth of the Kellogg National Seminar on Doctoral Preparation for Canadian nurses which took place in Ottawa in November, 1978.

Funding for Operation Bootstrap will be sought from the W.K. Kellogg Foundation, "the single most important outside source of funds in the history of Canadian nursing".

## Accreditation

Another long term project, accreditation of nursing education programs, will also be submitted to the Kellogg Foundation for possible funding as a result of a decision of CNA directors. A request from the association's ad hoc committee on accreditation that directors re-affirm the priority of this project was, however, turned down by the board.



**Health and Welfare Minister David Crombie** joined directors of the Canadian Nurses Association for a question and answer session during their recent three-day board meeting. Pictured above are (left to right): Dr. Shirley M. Stinson, CNA president-elect; Mr. Crombie; Helen Taylor, president of CNA; Dr. Helen Mussallem, executive director of CNA and Sheila O'Neill, the association's first vice-president.

## Continuing education

A third area which directors agreed should receive special attention in 1980 is that of continuing education. Members gave their wholehearted support to a resolution arising out of the National Continuing Education Conference in Winnipeg last Spring (see *The Canadian Nurse* June 1979) and supported by various provincial associations, "that CNA study the issues inherent in continuing education for nurses and produce a position paper on continuing education for registered nurses in Canada during the 1980-82 biennium." Directors agreed that, although they were not in a position to make a commitment on behalf of the board which will be elected for the coming biennium, they could and should endorse the presentation of this resolution to the first meeting of the new board following the CNA annual meeting in Vancouver in June.

## Standards

Members of the board were brought up-to-date on work on development of a definition of nursing practice and standards for nursing practice, recognized by CNA directors and membership as a priority in 1979. The project director reported that a seven-member task group is now meeting on a monthly basis in preparation for release of the final report in June, 1980.

## Ministerial visit

Recently appointed Minister of National Health and Welfare, the Honorable David Crombie, joined CNA directors for lunch on the second day of the meeting. The occasion marked the first official visit of a Minister of Health and Welfare to the headquarters of Canada's national organization of professional nursing associations.

In response to questions from the CNA directors, the Minister described some of the concerns prompting the current review of the status of publicly financed health insurance programs in Canada and said that the responsibility of the federal government in developing alternate methods of health care services and delivery systems, the cost of services and project funding will be determined after the Hall Commission review has been completed.

Mr. Crombie agreed with CNA directors who argued that the review to be carried out under the direction of Mr. Justice Emmett Hall should be called a report on "health care services '79", a term the directors preferred to "medicare". He emphasized that the Hall Commission is not a Royal Commission and that its terms of reference have an overriding objective — to achieve more efficient health care delivery at less cost while still maintaining quality. Directors informed the minister that CNA would be submitting a brief to be considered in the review process and that work has already begun on this project.

Mr. Crombie also discussed his proposal to establish a National Health Care Institute of Canada, an independent, non-profit corporation whose purpose would be to serve as a clearinghouse for information on the Canadian health system, monitor national health needs and report their assessment of the effectiveness of the system in meeting these needs. He described the institute as "an objective third-party that will guard the interests of users and providers of services."

Mr. Crombie and the directors discussed the expanding role of the nurse as well as federal and provincial responsibilities related to health care services. The minister said that he has been and will continue to meet with national health care organizations to establish productive working relationships.

## Other business

Directors approved a resolution requesting the Canadian Institute of Child Health to convene a task force whose members would investigate the redefinition of roles of the nurse and physician in the light of changes that are occurring in maternity care in Canada today. Members of the task force would also be asked to look at the changing role of the nurse-midwife.

Members of the board welcomed two new directors to their Fall meeting: Stephany Grasset and Jeanette Pick, presidents of the British Columbia and Alberta associations respectively. NBARN executive director, Bonnie Hoyt, was also attending her first CNA board meeting as provincial adviser.



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## CNA executive director addresses "nurses in the marketplace"

"Creative caring" was the theme of the 8th annual Ontario Occupational Health Nurses' Conference held in Toronto last October and attended by close to 400 nurses. Dr. Helen Mussallem, executive director of the Canadian Nurses Association, gave the keynote address. Her speech prompted a standing ovation and comments afterwards on the "exciting" quality of her address.

Dr. Mussallem said she believes that occupational health nurses have perhaps "the greatest and most unique opportunity to demonstrate and be involved in creative caring." The promotion of "healthful lifestyles" is important, she said, rather than concentration solely on the curing of illness. Dr. Mussallem regretted that the true "potential of nurses has never been realized...nurses are trapped in bureaucratic systems in the hospital and in the community." She closed by saying that in life the tragic people are those who "elect to be spectators" while occupational health nurses are in the dramatic position of practicing creative caring "in the marketplace".

Occupational health nurses are often the first contact an employee has with a health professional; these nurses therefore feel the need to be aware of all the possibilities in illness or dysfunction and all the resources available to them. The choice of speakers for the conference reflected this concern: presentations included an overview of communication techniques for use in relationship therapy, the importance of pre-retirement counseling and a discussion by Dr. John Jameson of Toronto on common phobias and their treatment.

One of the problems commonly experienced by OHN's is a result of their position vis à vis management and fellow employees; difficulties are encountered in getting health programs "off the ground", and employees frequently see the nurse as part of management with whom they do not feel free to discuss personal problems. Evidence of this problem surfaced when Justice Horace Krever spoke about the confidentiality of medical records and nurses in the audience told him they are often under pressure to reveal confidential information to employers. Justice Krever asked the nurses to send him more information.

A presentation entitled 'Management's View of the Nurse' was given by Dr. G.H. Collings, medical director of New York Telephone. Dr. Collings stated that the image of an industrial health service ranged from that of a regular department with its own important function to that of a mere overhead expense required by law. The nurse's role varies correspondingly, he said, from a skilled worker with no influence to an integral member of the management team. To be fair, Dr. Collings said, "only rarely can a business afford the generosity of affording services that are not directly aimed at running the business." He emphasized that the nurse must understand this and work not only at providing good health care to the employees but also offering the company realistic help that it cannot refuse on economic grounds. In short, he said, how management views the company nurse is in fact, up to the nurse.

**Columnist Corinne Sklar, author of *You and the law*, will return next month with another of her regular columns on legal issues affecting the nursing profession.**





FOR  
THE  
CANADIAN  
NURSE

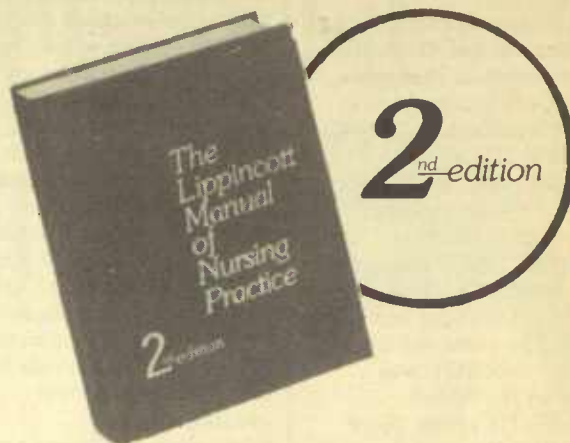
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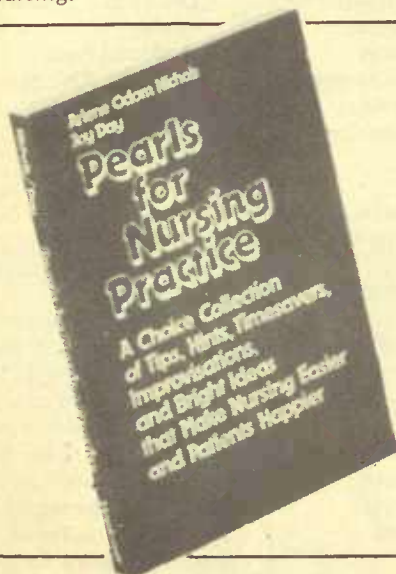
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## 2 PEARLS FOR NURSING PRACTICE: A Choice Collection of Tips, Hints, Improvisations and Bright Ideas That Make Nursing Easier and Patients Happier

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Lippincott. 250 Pages.  
Illustrated. Sept. 1979. \$10.50.

## 3 NURSES' DRUG REFERENCE

Edited by Stewart M. Brooks, M.S.

Little, Brown. 625 Pages.  
1978. \$14.50.

## 4 NURSING MANAGEMENT FOR THE ELDERLY

By Doris Carnevali, B.S., M.N.; and Maxine  
Lambrecht Patrick, B.S.N., M.S.N., D.P.H.

Lippincott. 570 Pages.  
Sept. 1979. \$22.50.

## 5 GERONTOLOGICAL NURSING

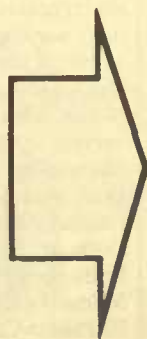
By Charlotte K. Eliopoulos, R.N., M.S.

Harper & Row. 384 Pages.  
Illustrated. 1979. \$15.00.

## 6 A GUIDE TO PHYSICAL EXAMINATION, 2nd Edition

By Barbara Bates, M.D.

Lippincott. 440 Pages.  
Illustrated. 1979. \$27.00.



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## Enterostomal therapists hold Canadian meeting

The 12th annual conference of the International Association of Enterostomal Therapists (IAET) will take place next year in Washington, DC, from May 22 to 25.

Last year's conference, in May 1979, was a huge success, drawing 500 registrants from Canada, the US, Mexico, Sweden, Australia, Germany and South Africa. The event, which was held in Vancouver, was hosted by the British Columbia ET group. More than half of the total Canadian membership of close to 100 ET's were in attendance.

Nurses interested in obtaining more information about the Canadian branch of the ET's should contact Linda Thomas, public relations chairman, 3768 Bathurst Street, Apt. 214, Toronto, Ontario, M3H 3M7.

**Any Question About Pediatric Nursing?** The Department of Nursing of the Hospital for Sick Children, Toronto, would like to help. Nurses are invited to call for information or consultation. Call the Medical Information Center (416) 597-1500, Extension 2620 and you will be referred to the appropriate resource nurse.

## Torture and the nurse

The Canadian Medical Group, part of Amnesty International, has sponsored a seminar for health professionals dealing with the victims of political torture. The meeting took place in Toronto last October. A number of nurses attended the seminar and in groups discussed the role of the nurse in the rehabilitation and treatment of torture victims.

Sponsors pointed out that nurses and doctors in Canada deal with torture on two levels: in treating the victims as they arrive in Canada from other countries, and in collaborating with professionals from nations where torture is prevalent.

Topics of discussion ranged from the physical and psychological results of torture, and proposed government response to refugee applications where torture has been medically assessed.

**Did you know...** Vancouver's St. Paul's Hospital has now certified 38 enterostomal therapists, all graduates of their Enterostomal Therapy Educational Program for Nurses. The only Canadian I.A.E.T. approved program currently available, St. Paul's is now accepting applications for the seven week program beginning November 3, 1980.

## Nurses in the news

**Helen Glass**, director of the School of Nursing, University of Manitoba was awarded the YWCA Woman of the Year award for Education. She is nationally and internationally recognized for her work as a nursing educator and has made a significant impact on the nursing profession as a whole. Glass is a strong protagonist on behalf of women's rights and for the professional status of nursing.

**Jeanette Pick**, president of the Alberta Association of Registered Nurses, was one of six "Women of the Year" honored last Fall by the Calgary branch of the YMCA. Pick, who is assistant director at the Foothills Hospital School of Nursing, was winner in the health category of the awards which were given to mark "50 years of personhood".

**Marie-Therese Laliberte**, a Master's level student at the Faculty of Nursing, University of Montreal, was recently awarded a Warner-Lambert Canada Limited nursing fellowship award by the Parke-Davis Division. This \$750 grant is made to selected candidates for the degree of Master of Science in Nursing at Canadian universities.

**Eleanor Nolan and Elizabeth Cochrane**, who have been awarded the 1979 Judy Hill Memorial Scholarship, will each receive \$3500 to continue their nursing education for eventual service in the Canadian Arctic. Eleanor Nolan, who began her nursing service in St. John's, Nfld., has worked in Labrador, Frobisher Bay, Australia and Ireland. She is enrolled in the Outpost Nursing and Midwifery program at Memorial University, Nfld. Elizabeth Cochrane, a graduate of Conestoga College, Kitchener, Ontario, is presently studying midwifery at the Aberdeen Maternity Hospital, Scotland.

The New Brunswick Association of Registered Nurses has announced the names of 11 scholarship recipients for the 1979-80 year. These scholarships are awarded on the condition that the recipient work in New Brunswick for a specified period of time after graduation.

**Karon Croll** was awarded \$1250 for studies toward a Doctorate in Adult Education at Florida State University and **Lynne McGuire**, who is enrolled in the Master's in Education of Nursing Program at the University of New Brunswick, received a \$750 scholarship.

The Muriel Archibald Scholarship, valued at \$1200 will be shared equally by **Frankie Fung, RN**, Saint John and **Nicole Roy RN**, Shédiac, who are working towards their Baccalaureate of Nursing Degrees at the University of New Brunswick and the Université de Moncton, respectively.

NBARN scholarships valued between \$300 and \$775 have been awarded to the following who are studying towards a Baccalaureate of Nursing Degree: **Jane Bartlett**, Woodstock; **Elaine Bell**, Woodstock; **Pierrette Brun**, Cap-Pelé; **Sylvie Parisé**, Caraquet; **Sandra Stever**, Bathurst; **Francine Thibault**, Ste. Anne de Madawaska; **Mariette LeBlanc**, Moncton.

**Did you know...** A 42-year-old grandmother from Windsor, Ontario, was among 32 Canadians who received bursaries from the St. John Ambulance last year, enabling them to pursue or advance their nursing careers. Marilyn Roberts, mother of five and grandmother of four children, was awarded the Margaret MacLaren Memorial Bursary in August and is now attending St. Clair College in Windsor. Nine other winners are taking post basic training and one is studying for her Master's. Deadline for applications for this year's bursaries is May 1, 1980. Write: St. John Ambulance, National Headquarters, P.O. Box 388, Terminal 'A', Ottawa, Ontario, K1N 8V4.4

## Notice of meeting CANADIAN NURSES FOUNDATION

In accordance with Bylaw, Section 36, notice is given of an annual general meeting to be held on Sunday, 22 June 1980, commencing at 14:00 at the Hyatt Regency Hotel, Plaza Ballroom, (East/Center), Vancouver, British Columbia.

The purpose of the meeting is to receive and consider the income and expenditure account, balance sheet and annual reports.

The election of the CNF Board of Directors for the 1980-82 term of office will be conducted during the meeting.

All members of the Canadian Nurses Foundation are eligible to attend and participate in the annual general meeting.

*Helen K. Mussallem  
Secretary-Treasurer  
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<b>Alaska</b>	1-3 days — from \$40
“The Island Princess cruise”	
June 27 - July 5	
U.S. \$1500-1600	
<b>Victoria</b>	1-3 days — from \$40
<b>The Royal Hudson Steam Train Excursion</b>	10 hours — \$30

Details will be in the February issue of *The Canadian Nurse* and advance reservations will be essential.

In the meantime, the RNABC Hosting Committee needs your help in estimating demand.

Cut and return to:

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## CNA moves West for 1980 meeting

### ‘Today’s issues - tomorrow’s nursing’

*Something for everyone. That’s the claim of this year’s program organizers who have been hard at work on planning an action-packed agenda for CNA’s annual meeting and convention in Vancouver. Highlights will include:*

- A special Kellogg Lecture on the nurse’s role in delivering primary health care by Dr. Lea Zwanger, head of the division of Allied health professions, Ministry of Health, Tel Aviv, Israel.
- “Who shapes nursing in the eighties?”, the keynote address for the convention, will be delivered by Lorine Besel, director of nursing at the Royal Victoria Hospital in Montreal.
- A special session on the health care dollar featuring a noted commentator from the Canadian economic scene.
- A panel presentation on the labor movement vis à vis the professional association featuring discussion between a labor analyst and two members of the nursing profession.
- A debate on the always controversial question of mandatory versus voluntary continuing education.
- A social program that will include a wine and cheese reception as well as a dinner featuring entertainment with a B.C. flavor.

*This year’s theme — “Today’s issues — tomorrow’s nursing” — leaves no doubt about the relevance of the 1980 program. So, plan on keeping up, keeping informed. Make sure you’re there.*







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Annual meeting and convention  
Hyatt Regency Hotel  
Vancouver, B.C.  
June 22-25, 1980.

### Registration Fee

(includes Monday luncheon and Tuesday dinner)

Three days    Daily rate

■ CNA member	\$100/	40
■ Non-member	\$150/	60
■ Nursing student	\$40/	20

I wish to attend (days circled)

Monday

Tuesday

Wednesday

Please mail my receipt, admission card  
with convention kit, ticket and  
procedure for registration to:

Name \_\_\_\_\_

(Surname first) \_\_\_\_\_

Address \_\_\_\_\_

Present employer \_\_\_\_\_

Prov/Terr of Reg'n \_\_\_\_\_

Reg'n No. \_\_\_\_\_

I enclose cheque or money order payable  
to Canadian Nurses Association, 50 The  
Driveway, Ottawa, Ontario, K2P 1E2.

■ I wish to receive a reservation card  
for accommodation at the Hyatt Regency.

(See December CNJ for details of other  
accommodation)



# names & faces

**Stephany Grasset** of Vancouver has been elected president of the RNABC for a two year term. A nursing instructor at the British Columbia Institute of Technology, she has a long record of participation in association affairs and is experienced in both hospital and public health nursing.

**Heather Caloren, BScN, MScN**, has been appointed Assistant Director - Nursing Service for the Elderly with the Victorian Order of Nurses for Canada. A graduate of the University of Toronto School of Nursing, she will be providing advisory and consultative services related to program development at the branch level, developing and establishing educational programs for VON staff and maintaining liaison with government departments and other voluntary agencies.

The **Edith Dick Fund** has been established in memory of the life and work of the late Edith Rainsford Dick, an inspector and director with the Ontario Department of Health from 1932 until 1964. Widely respected for her contribution to health services and nursing in Ontario and Canada, her efforts in the Second World War were recognized by King George VI in 1944 with the Royal Red Cross, first class. The fund will be administered by the RNAO Foundation to develop and promote nursing practice in response to changing health needs.

**Carol Hoganson, RN**, a former employee of the Halifax Infirmary operating room, has won the Deknatel Educational Award for Canada for her invention of an intravenous clamp which more accurately controls the flow of intravenous solutions.

**Donna Meagher (B.Sc.N., Mount St. Vincent University)** and **Sheila Ross (B.N., McGill University)** both of Halifax, are co-winners of the Frances MacDonald Moss Scholarship awarded annually by the Registered Nurses Association of Nova Scotia. The scholarship of not less than \$3000 is awarded to members of the Association wishing to undertake further education in nursing. The winners will each receive \$1500.

Meagher, currently on the Faculty of the School of Nursing at Dalhousie University will begin studies for a Master's degree in Health Sciences at McMaster University, Hamilton, Ontario, who is assistant director of nursing at the Victoria General Hospital, Halifax will begin studies for an M.N. at the Dalhousie School of Nursing.

**Sister Anne Deas, S.S.A.**, formerly Director of Nursing, St. Joseph's Hospital, Victoria and St. Boniface General Hospital, Winnipeg, has been appointed Director of Nursing, St. Paul's Hospital (Grey Nuns') of Saskatoon, Saskatchewan. She is a graduate of Gonzaga University, Spokane, Washington (BScN), and the Catholic University of America in Washington D.C. (Master of Nursing Service Administration).

**Jean Rose** has been appointed to the position of Nursing Consultant-Education with the Association of Registered Nurses of Newfoundland. A graduate of Sydney City Hospital School of Nursing, Sydney, N.S., Dalhousie University (B.N.) and Boston University School of Nursing, Boston, Mass. (M.Sc.N.), she has had a variety of clinical experience and has chaired the Nursing Education Committee of the RNANS and the Nursing Education Committee of the College of Cape Breton, N.S.

**Mary E. Murphy** has recently been appointed Vice-President, Nursing at the Vancouver General Hospital. A graduate of St. Joseph's School of Nursing, London, Ontario; University of Windsor (BScN) and the University of Ottawa (MHA), she has held many supervisory and administrative positions. Most recently, she has been Vice-President, Nursing with the University of Alberta Hospital in Edmonton, Alberta.

Always active in her professional associations, Murphy is currently Chairman of the Ad Hoc Committee on Graduate Education of the Alberta Association of Registered Nurses.

**Thelma Jane May (R.N., School of Nursing, Hospital for Sick Children; B.Sc.N., University of Toronto)** has been appointed director, Nursing Service at the Bloorview Children's Hospital, Toronto. She first went to Bloorview in 1975 and since then has served as administrative supervisor and assistant director of Nursing Service. Previously, May held administrative positions at the Hospital for Sick Children and at Women's College Hospital in Toronto.

May is also actively involved in the St. John Ambulance Brigade and is currently chairman of the Nursing Advisory Committee of that association.

**Rosette Leduc-Grand'Maison** has received the United Nurses Award of Merit for having rescued a child from drowning in 1978. The United Nurses Inc., P.Q., annually honors a nurse whose achievement during the past year has warranted public recognition and has enhanced the profession of nursing. Certificates of merit have also been awarded to Diane Roy of Ste-Justine Hospital and Yvette Pratte-Marchessault of Notre Dame Hospital, Montreal.



Western Australian Institute of Technology

## Department of Nursing

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Teach and arrange clinical placements for nursing students in the diploma and Bachelor of Applied Science courses (Community Nursing Practice).

Applicants must be registered general nurses with recent experience of health care delivery in community settings. Preference given to applicants with degree or additional appropriate qualification.

**Salary Range:** Lecturer: \$C21,067 — \$27,677. Senior Tutor: \$C18,158 — \$C20,801. (October 26 Exchange Rate)

**Tenure:** The above position is available with permanent tenure. However the Institute is interested in receiving applications from persons preferring a limited term appointment.

**Conditions Include:** Four weeks annual leave, fares for appointee and family plus some assistance for removal expenses. Superannuation is available for staff with permanent Tenure. Return fares are provided for staff appointed for a Limited Term.

**Applications:** Detailed application including the names and addresses of three referees should be submitted not later than 31st January to the Appointments Officer, Western Australian Institute of Technology, Hayman Road, South Bentley 6102, Western Australia.

When applying please quote position reference number and media code CN3.



**Margaret Scott Wright**, the present director of the School of Nursing at Dalhousie University, Halifax has been appointed dean of nursing at the University of Calgary.

Scott Wright obtained her doctor of philosophy degree in the faculty of medicine at the University of Edinburgh where she later became director of the department of nursing studies in the faculty of social science. In addition to serving on many government and professional committees in the U.K. and Europe, she was vice-president of the International Council of Nurses and acted as an advisor and consultant to the World Health Organization on many occasions.

Scott Wright begins her five year appointment as dean of nursing at U of C on Sept. 1, 1979 succeeding Marguerite Schumacher who will remain in the faculty.

**Joyce Perrin**, BScN, DHA, has recently been appointed to the position of administrator of the Bloorview Children's Hospital, Willowdale, Ontario. A graduate of the University of Alberta School of Nursing and the University of Toronto School of Hospital Administration, she has held many nursing and administrative positions, most recently Assistant Executive Director of the Canadian Council on Hospital Accreditation.

Three Alberta nurses received scholarships from the professional association in that province this year. AARN scholarship winners are: **Walter Bredlow** and **Linda Reutter**. Bredlow, a clinical nurse specialist in Medicine Hat, is now enrolled in the second year of a doctoral program in marital and family therapy in California; Linda Reutter, a community health nurse in Edmonton, has entered the University of Colorado this Fall to complete a Master of Science degree in

Community Health Nursing.

A third scholarship was received by **Elizabeth Millham**, instructor/coordinator at the Holy Cross School of Nursing in Calgary, now enrolled in the final year of a Masters in Educational Administration Program at the University of Calgary.

**Irene Ross McPhail**, R.N., was recently elected president of the St. John Ambulance Federal District Council, the first time that this position has been held by a woman.

McPhail, a graduate of the University of Alberta Hospital and the Medical Centre of Cornell University, joined the Federal District Council in 1964 as provincial nursing officer and two years later became the provincial superintendent of nursing. In 1972 she was appointed provincial commissioner — another first for a woman.

Apart from her outstanding service to the Federal District Council, McPhail has also contributed substantially at the national level. Through her active interest in the field of health care, she has provided valuable consultation in the development of the expanded St. John Ambulance home nursing program.

In recognition of her contributions to St. John Ambulance, McPhail holds the grade of Dame of Grace, one of the highest honors awarded by the Order of St. John.

**Carol Roberts**, a graduate of the Royal Victoria Hospital School of Nursing, Memorial University (B.N.) and Boston University, Mass. (M.Sc.N.) has been appointed Nursing Consultant-Practice with the Association of Registered Nurses of Newfoundland. She has worked in various capacities in medical, surgical and pediatric nursing and most recently taught medical-surgical nursing at the University of Ottawa School of Nursing.

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## Back to basics, nursing educators face up to needs of the eighties



*Reaction panel members at CNA's national forum on nursing education were (left to right): Jocelyn Hezekiah, Cécile Lambert, keynote speaker Alice Baumgart, chairman Margaret McCrady, Dorothy Kergin and Ann Hilton.*

Canada's top nursing educators, faced with the warning that they do not have unlimited time to debate the issues involved in preparing tomorrow's practitioners, came up against a wall of words at their first national seminar in Ottawa in mid-November.

The warning that the clock was running out came on the first day of the three-day conference and was delivered by keynote speaker, Alice M. Baumgart, dean and professor at Queen's University School of Nursing in Kingston, Ontario. Baumgart reminded her 350 fellow nurses attending the meeting of "the growing urgency of setting out clearly the differences in the roles and competencies of the various types of nursing practitioners."

"Time is running out for nursing to put its educational house in order," she warned. "Out of enlightened self-interest, nursing educators should get on with this task. Otherwise, necessary choices will be made increasingly by others, often to the detriment of nursing and patient care."

Baumgart called on nurses to begin work on the development of a "comprehensive and long term systems approach" to planning basic nursing education and predicted that critical questions related to basic nursing education in the eighties will center around the overall responsibilities of the system, specifically, the problems of managing with increasingly limited resources and the need to develop

political processes that encourage responsiveness and accommodation, rather than confrontation and restricted action.

The National Forum on Nursing Education, the first of its kind in Canada, was sponsored by the Canadian Nurses Association and grew out of a resolution approved by delegates to CNA's annual meeting in Toronto last June. More than 200 of the 343 participants were educators who represented a total of 41 community colleges, 22 university schools of nursing and 21 hospital schools of nursing from right across the country.

The conference theme, "The nature of nursing education", gave rise to speeches and debate on the following subjects:

- basic nursing education
- implementing the curriculum based on a nursing model
- basic nursing service
- nursing skills/competencies
- perceptions of the new practitioner
- specialization in nursing
- national accreditation of nursing education programs.

In the end, following three days of discussion, delegates approved the principle of holding other similar conferences on nursing education, with the proviso that in the future one or two issues be chosen for examination at each conference. They suggested that the focus for the next conference should be an examination of the clinical component in basic nursing programs.

Speakers taking part in the panel discussion that followed the keynote address focused on some of the key issues facing nurse educators today. "Nurses must realize they cannot be all things to all people," Dorothy Kergin, director of the University of Victoria School of Nursing, warned her audience. The former associate dean of Health Sciences (Nursing) at McMaster University spoke of the growing need for collaboration and close working relationships between nurse practitioners and educators. Two of the critical questions that nurses must ask themselves, she said, are who is going to set standards for nursing education and what are the health needs that nursing must address.

The three other members of the panel included the president of the Registered Nurses Association of Ontario, Jocelyn Hezekiah, who is chairman of basic nursing programs in the Health Sciences Division of Humber College of Applied Arts and Technology in Toronto; Cécile Lambert, professor at Maisonneuve College in Montreal and provincial coordinator for diploma nursing programs in Québec; and Ann Hilton, assistant professor, Faculty of Nursing at the University of British Columbia.

### What is nursing?

"What is a nurse, what does a nurse do?" The answer, according to Evelyn Adam, associate professor of nursing at the University of Montreal, lies in our mental picture of nursing, how we conceptualize our profession. Nurses now want recognition of not only their dependent role, but also their independent or autonomous role — a role which is not entirely clear and therefore not easily communicated to others. The solution according to Adam, whose address was titled "Issues in implementing the curriculum based on a nursing model", lies in adoption of a conceptual model, i.e. a way of looking at nursing that is precise and explicit enough to give nurses direction for practice, education and research.

### Nursing skills and service

Four nurses, Marie Cruise, Ginette Rodger, Lucille Parent and Marie White, presented four different aspects of "Nursing service — what is it?" on the morning of the second day of the conference. Marie White, director of inservice education at Sir Thomas Roddick Hospital in Stephenville, Newfoundland, spoke on nursing service





*Evelyn Adam*

in a small hospital and commented that the character of service depends on a number of factors such as management philosophy, accreditation status and available manpower. She said that nurses told her they felt nursing service was becoming more task-oriented because of manpower constraints, and many felt unhappy that they were performing those tasks for which they would be held accountable by supervisory staff — in other words, they were “just doing the things that showed”. In discussion afterward, Alice Baumgart commented that nurses were still performing the “housewife and mother” function in health care, keeping everything together and going. Ginette Rodger, director of nursing at Notre Dame Hospital in Montreal, said that “it is useless for us to get together like this (nursing service and educators) and just complain at each other,” and she added that practice and education must go hand in hand to keep pace with the kind of service nurses wish to provide.

The theme of skills versus theory continued when Margaret Steed, associate professor at the University of Alberta, gave a paper on “Whatever happened to nursing skills?” She made note of the controversy about the new nursing graduates, that critics say today’s new grads are not prepared to do ‘real nursing’. She acknowledged that “the basic nursing programs cannot and will not be able to provide all the skills essential to work in health care.” The answer in part has been to develop the trend toward competency-based education which attempts to provide graduates with marketable skills based on the needs specific to a particular situation. Steed concluded by saying that educators cannot be smug about the needs of the new nursing graduate, but neither can those involved in nursing practice fail to acknowledge the necessity of a theoretical knowledge base; education and service must work together to build professional nursing practice.

Following this presentation two recent nursing graduates, Margaret Edmonds, staff nurse at Victoria General Hospital in B.C., and Heather Smith, who is studying for her post-RN BScN degree, spoke on their experiences as new practitioners; both stated that they wondered if the transition from student to graduate wouldn’t have been easier if they had had more clinical experience during their education period. Patricia Stanojevic, special projects officer at George Brown College in Toronto, in her paper “Reducing Reality Shock” allowed that this phenomena was not unique to nursing, that the graduates of many professions experienced the same



*Heather Smith*

sort of feeling once thrust into the role of practitioner. An RNAO project investigating reality shock identified the need to sensitize the nursing student to the real world through planned learning activities and the need for nursing education programs and health care agencies to work together to ease the transition for new practitioners. This might be accomplished through individualized hospital orientation programs, she said.



*Margaret Edmonds*

### **The nurse specialist**

Specialization in nursing was the theme of Madeleine Blais’ presentation on the final morning of the conference. She defined the nurse specialist as “one who has acquired specific knowledge either by formal education or by the kind of experience which fosters the development of specific knowledge and skills.” Blais is the nurse responsible for nursing education research for the Order of Nurses of Quebec, and is also vice-president of the Commission for Adult Education of the Quebec Council of Advanced Education.

### **A chequered history**

The notion of a system for the accreditation of educational programs in nursing goes back to the thirties when nursing associations in this country first suggested that there should be a body charged with responsibility for Dominion-wide registration for nurses.

The Canadian Nurses Association, according to CNA’s second vice-president Myrtle Crawford, who is also professor and assistant dean of the College of Nursing of the University of Saskatchewan, approved the principle of accreditation in 1945 and, at that time, set up the first of numerous committees charged with examining the question. Crawford described the procedure since then as one of “alternately approving the principle, appointing a committee or study group to consider the question and then, finally, backing away from the decision.”

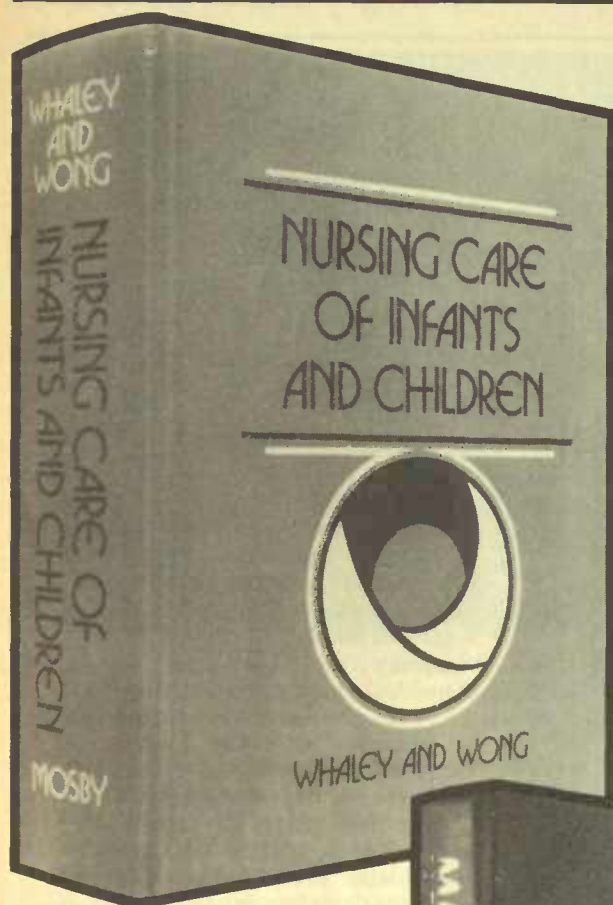
Along the way there have been several notable landmarks, including an evaluation of Canadian schools of nursing carried out by the current executive director of CNA, Helen Mussallem, which resulted in publication of the report, “Spotlight on nursing education”.

The most recent attempt involves an ad hoc committee set up by CNA directors in response to a resolution passed at the association’s 1978 annual meeting. This committee, working with representatives of the Canadian Association of University Schools of Nursing who have had an accreditation project underway for several years, has now come up with a proposal that CNA directors approved at their last board meeting. Funding for the project, which will cost in the neighborhood of \$800,000, is being sought from the W.K. Kellogg Foundation.

Crawford warned, however, that the outlook for this proposal is “not overwhelmingly favorable” since the



# Mosby is the nursing publisher.



*A New Book!*

## **NURSING CARE OF INFANTS AND CHILDREN**

By Lucille F. Whaley, R.N., M.S. and Donna L. Wong, R.N., M.N., P.N.P.; with 5 contributors.

This outstanding volume provides a comprehensive approach to the care of the well, ill and handicapped children. By applying principles of normal growth and development, it discusses the implementation of physical assessment in planning care . . . offers a conceptual understanding of pathologic processes . . . and describes those nursing interventions essential to restoring health/functioning.

Consistent throughout, chapters reflect a dual concern

for promoting the health of the well child and caring for the ill or disabled child. Highlights include:

- a distributive nursing care approach;
- summaries of nursing care that offer guidelines for action follow major sections;
- emphasis on and guidelines for communicating with children and their families;
- lab data and pharmacology are incorporated throughout.

Numerous quality tables and illustrations clarify common conditions and nursing care. This volume presents both an effective developmental framework, and a systems orientation. Why not evaluate it for yourself?

March, 1979. 1,734 pages. 746 illustrations. Price, \$26.50.

## **MATERNITY CARE: The Nurse and the Family**

By Margaret Duncan Jensen, R.N., M.S.; Ralph C. Benson, M.D.; and Irene M. Bobak, R.N., M.S.; with 2 contributors.

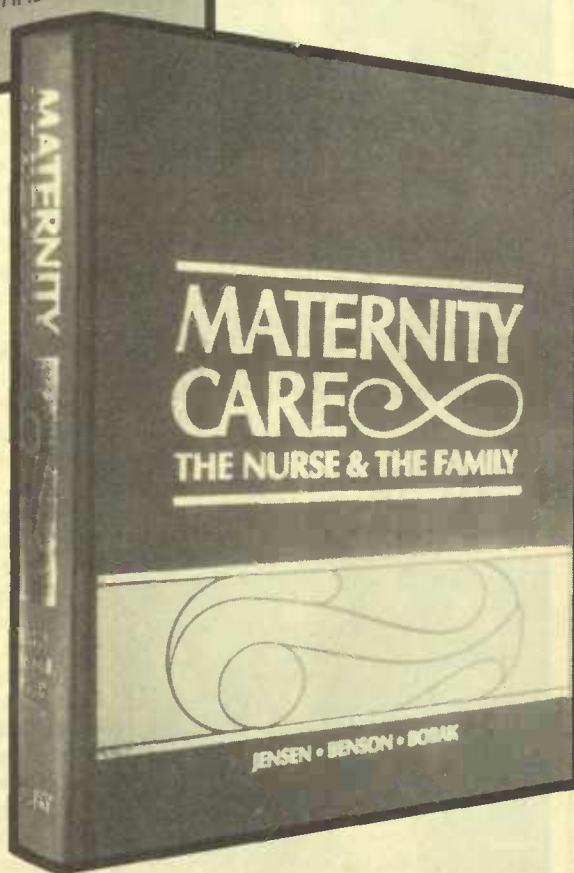
Both contemporary and humanistic in approach, this important volume can help the student function more effectively as a maternity nurse in today's changing society. Following the chronologic order of childbirth, it discusses the biopsychosocial aspects of human sexuality, then proceeds to family planning, pregnancy, interferences with normal pregnancy, labor and its complications, the postpartum period, and both normal and high-risk infants. Throughout, the authors:

- integrate diagnostic, therapeutic, and educational objectives;
- present intervention plans;
- and combine clinical and psychosocial aspects to provide a unique view of total patient and family care.

Timely discussions explore such key topics as genetics, legal factors, fathering, and P.O.M.R. Over 600 illustrations highlight plans for nursing intervention.

1977. 784 pages, 684 illustrations. Price, \$24.00.

*A New Book!* **FAMILY-CENTERED MATERNITY/NEWBORN CARE: A Basic Text.** By Celeste R. Phillips, R.N., M.S. This modularized text offers a family-centered approach to basic maternity care. Well-illustrated units cover all aspects — from pertinent anatomy/physiology, conception, the antepartum family, and preparation for childbirth to the intrapartum family with complications, the newborn, and trends in childbearing. Each unit: states goals; identifies behavioral objectives (keyed throughout the text); and concludes with evaluation exercises. April, 1980. Approx. 432 pages, 323 illustrations. About \$14.50.





A New Book!

## **HANDBOOK OF MATERNITY CARE: A Guide for Nursing Practice**

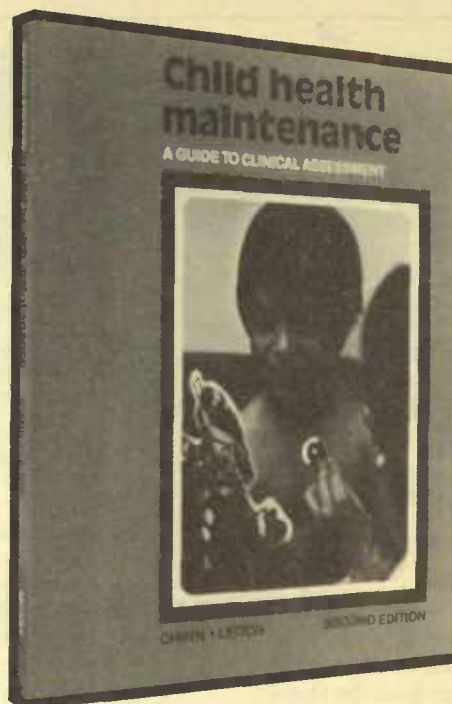
By Margaret Duncan Jensen, R.N., M.S. and Irene M. Bobak, R.N., M.S.

A convenient, practical supplement to any maternity care text, this new book explains how to care more effectively for women and families during the child-bearing cycle. All aspects are discussed from maternal adaptations, assessing the maternal/fetal/placental unit

and care plans for normal childbirth to high-risk condition, infertility and family planning. Highlights include:

- guidelines for assessing the maternal/fetal/placental unit;
- presents prenatal, natal and postnatal care plans for normal childbirth;
- delineates assessment and care of the normal newborn;
- cross-references all material for ready reference.

February, 1980. Approx. 304 pages, 133 illustrations. About \$12.00.



### **New 2nd Edition! CHILD HEALTH MAINTENANCE: A Guide to Clinical Assessment.**

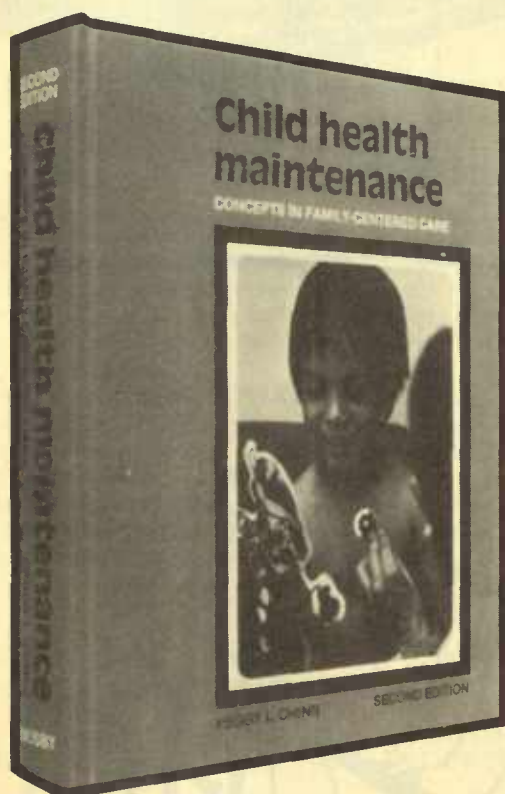
By Peggy L. Chinn, R.N., Ph.D. and Cynthia J. Leitch, R.N., Ph.D. This concise text serves as both a student-oriented learning guide for comprehensive health assessment and as a source of information for effective pediatric care. The authors present a wealth of information on developmental differences observed from birth through adolescence — indicating possible deviations and their health care implications. For added convenience, information needed to implement a care plan is cross referenced. March, 1979. 166 pages, 24 illustrations. Price, \$9.75.

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**When you want to refine, refresh, reassess...  
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◀p.17

association is already committed to two high profile, high priority projects — development of standards for nursing education and promotion of doctoral education for nursing in Canada.

"Canadian nursing will be successful in obtaining funding for this project and in finally establishing an accreditation program for nursing education in Canada only if it is wholeheartedly supported by Canadian nurses. If there is little enthusiasm for the goal of a national accreditation program this should be determined now and the question of accreditation put to rest for the next 30 years so that energies can be directed towards other high priority items of the profession. In my view it would be a serious mistake if this were to happen."

#### Finale

Canada's first nursing education conference closed with recommendations from the floor touching on various aspects of the

discussion during the preceding three days. Among the concerns voiced by participants were:

- the need to examine the clinical component in basic nursing education programs
- the need for collaboration between inservice departments in places of employment for nurses and educational programs
- the need for the national association to take a stand on whether basic preparation for entry into nursing should be at the baccalaureate level by a certain date
- the need for a "rotated internship" for new graduates that would be the responsibility of nursing education rather than the employing agency
- the idea of a mandatory clinical practice component for nursing instructors to be completed annually
- the need for increased communication between diploma and university nursing levels of education, along with consultation with the service

component in the development of nursing education programs.

Members of the committee responsible for planning the forum are: chairman **Margaret McCrady**, director of educational services, Nursing, Health Sciences Centre, Winnipeg; **Jessica Ryan**, head nurse, Pediatric Service, Chaleur General Hospital, Bathurst, N.B.; **Marie-Thérèse Choquette**, director of professional nursing for the Order of Nurses of Quebec; **Pat Kirkby**, coordinator of the Diploma Nursing program, Cambrian College, Sudbury, Ontario; **Ruth Elliott**, assistant professor, Faculty of Nursing, University of British Columbia.

"Back to basics", a report on the conference proceedings, including the text of all the papers presented, discussion and commentary, is now being prepared. Information on this publication will be carried in a subsequent issue of *The Canadian Nurse*.  
M.A.B.

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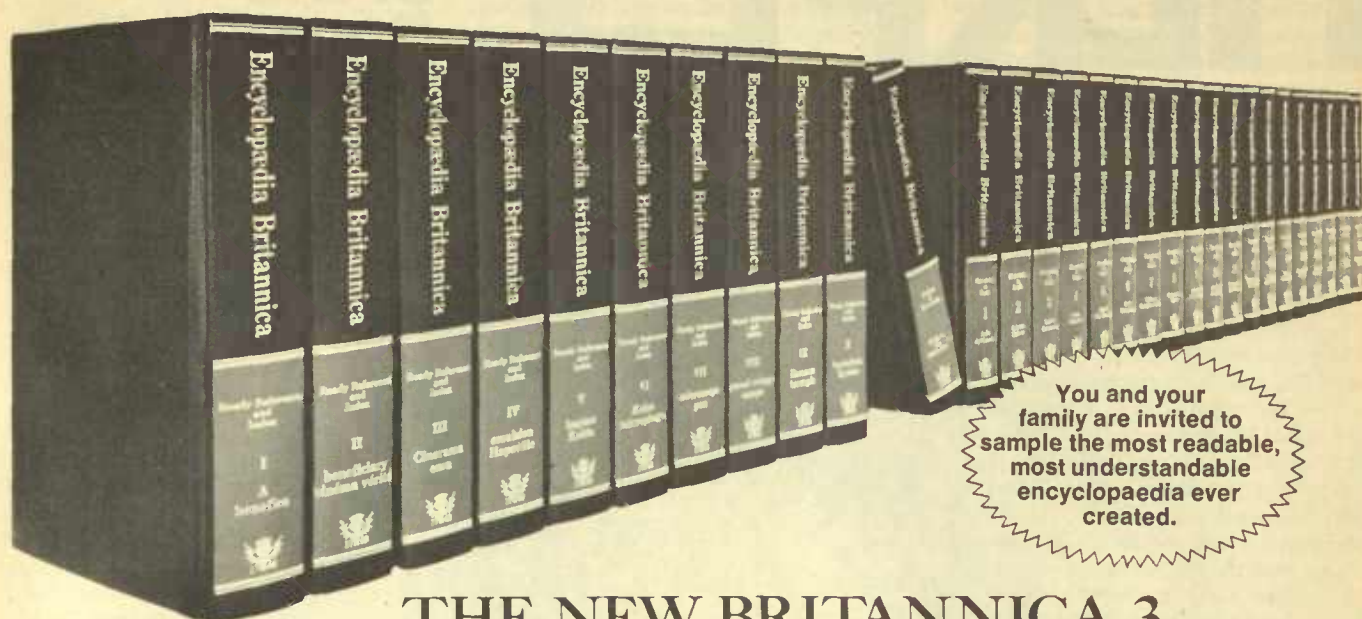
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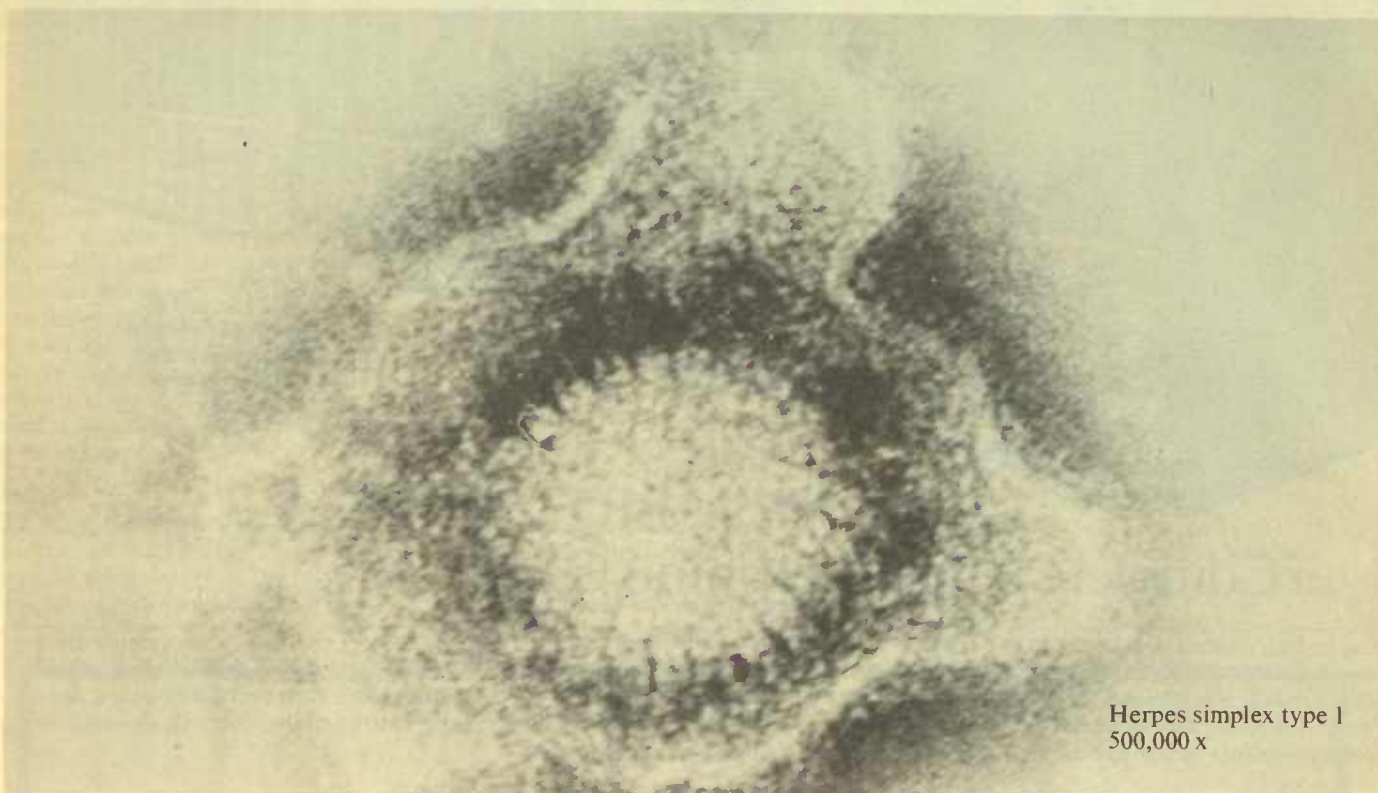
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# HERPES: Scourge of the Seventies

Jane Bock



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500,000 x

Photograph of Herpes Simplex Type 1 Virus (types 1 and 2 have similar appearance)

**HERPES**, a viral infection which manifests in distinctive skin lesions, or fever blisters, has been around for a long time. A Greek word meaning 'to creep', herpes is responsible for the common 'cold sore'. Now the herpes virus is causing concern because the type which affects the genital area, *herpes genitalis* (or simply, genital herpes) has been affecting young men and women in North America at an alarming rate. Transmitted through sexual contact, genital herpes is a venereal disease and is thought by some researchers to be responsible for some 13 per cent of cases of venereal disease in the U.S.<sup>1</sup> However, genital herpes is not a reportable disease, and so no statistics are likely to be accurate.

There is good reason for the concern: because all types of herpes are a latent infection, (see **Virus**) once an individual contracts a herpes infection he has it for the rest of his life. In addition to this danger of recurrence, genital herpes can cause severe problems in newborn babies, and can endanger the life of the unborn fetus. Further, some medical researchers believe genital herpes is linked to cervical cancer in women.

It is obvious then that nurses need to have some knowledge, not only of the genital type of herpes, but of the other types of this virus as well, especially since serious misconceptions exist about all forms of herpes.

There are four types of herpes virus that are most common. **Varicella-zoster virus**, often called shingles, appears as small reddened bumps on the skin of the trunk, arms and legs. Herpes is what is known as a neurotropic virus, meaning the virus lives in or remains latent in nerve tissue, and in some cases of herpes zoster this fact is most apparent. The bumps can be seen to follow networks of nerves, and on a patient's back may form a tree-like pattern. It is a common belief that if the "shingles meet, you'll die". This of course is not the case, and a nurse must ensure that her afflicted patient does not believe in this old wives' tale. Herpes zoster may appear later in life as a recurrence of chickenpox, which is caused by the same *varicella zoster* virus. The recurrence can be a very painful experience and herpes can in fact be life-threatening in patients receiving immuno-suppressants such as transplant patients and in newborns.

**Cytomegalovirus** is also a member of the herpes virus family. It rarely causes symptoms in adults but can cause a congenital infection in infants.

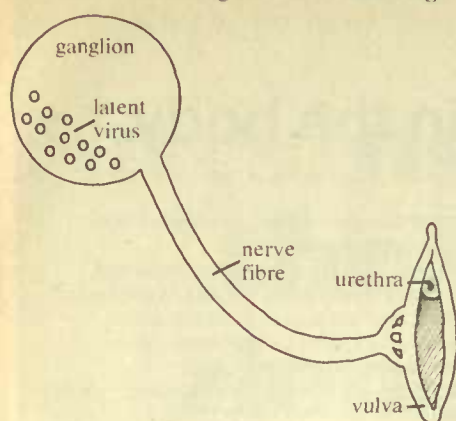
A third is the **Epstein Barr virus**, which is related to Burkitts lymphoma, a malignant tumor of the lymphoreticular system, which is found mainly in children in Africa.

The fourth type of herpes is **herpes simplex**, of which there are two groups, called simply 1 and 2. Herpes simplex 1 is responsible for most of the small sores appearing as blisters on the face, around the lips, often called "cold sores." Contrary to popular opinion, genital herpes is not always caused only by herpes simplex 2 (HSV2) — usually, but not always. In genital herpes the virus is spread generally through sexual contact,<sup>2</sup> and the viruses pass through the skin and mucous membranes to the nerve tissue. Incubation period is thought to be two to 20 days, with six days being the mean; duration of the initial infection is up to three weeks, while recurrences last usually about 10 days.

Photo: Regional virus lab, Children's Hospital of Eastern Ontario



Figure one: Latent stage

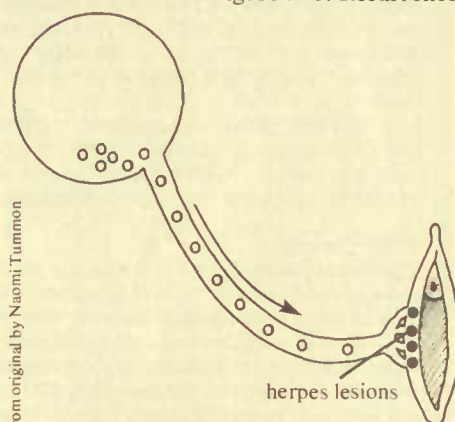


The current aim in finding a cure is to stop the herpes virus from becoming latent, or from reaching the ganglia where it remains for the duration of a patient's life; this means that whatever treatment is going to be tried, speed is important, and patients must seek treatment as soon as possible.

### Recurrence

Because the herpes simplex virus is neurotropic, it can remain inside the ganglion of nerve tissue in a latent state, and recur again at any time. It is not clear what precipitates recurrence — stress, illness, menstruation — but about half of all patients with genital herpes experience some form. The lesions may reappear once every six months, or once a month.

Figure two: Recurrence



Drawings from original by Naomi Tummon

*Diagrams are schematic*

### Special danger

Genital herpes is an especially dangerous infection for a number of reasons. It spreads rapidly and unlike other diseases spread by sexual contact, cannot be stopped or cured with a course of antibiotics. There are dangers especially to women; there is a one in three chance that a woman who contracts genital herpes while pregnant will abort; the virus can spread to the fetus at delivery from the vagina, so Caesarean delivery is indicated for women who have either active or recurring cases of genital herpes.<sup>8</sup> Infants delivered from women who have genital herpes lesions should be isolated in the nursery for 10 to 12 days.<sup>9</sup>

Herpes in the neonate is, in one doctor's words, "devastating".<sup>10</sup> The herpes simplex virus is also a causative organism in encephalomyelitis,<sup>11</sup> and the newborn infant is especially susceptible. The virus attacks the baby's entire nervous system, and death can result.

Much has been written about a possible connection between genital herpes and cervical cancer in women, based on certain animal studies. Although it is true that the majority of women who have genital herpes do have cervical involvement, one physician suggests that both herpes and cancer are "co-variables of a certain sexual lifestyle",<sup>12</sup> and that one does not necessarily cause the other. Still, it is recommended that women with a history of genital herpes have regular Pap smears done.

### Herpes and the nurse

One might ask, what can a nurse do to help people who have this disease when there is no adequate treatment and even doctors are at a loss to help their patients? That, according to Dr. Ian Tummon, a resident in gynecology at the Ottawa General Hospital who is doing research with herpes patients, is exactly the reason why nurses are so important. "People with genital herpes have special emotional problems," Dr. Tummon says, and he adds that due to the depressing prognosis of recurrence without treatment, and the means of transmission of the disease, "these people need a lot of support and reassurance." He said that it might be of help to patients for them "just to know that you know they're suffering."

A patient might feel that her having contracted genital herpes means that she is "paying" for having had a casual sexual encounter; there may be strong feelings of anger and hurt directed against the person who 'gave' her the virus. One patient, whose herpes recurs every month with her menstrual period said, "Every time I get it I don't know whether to kill myself or to find Richard and kill him." One must not forget too that these patients suffer from the stigma of having a 'social disease', and that they have to guard forever after against giving it to other partners. "This is difficult," Dr. Tummon points out, because admitting that one has an infectious venereal disease means they run the risk of losing the relationship. "But if you care about someone," he says, "they have to be told."

Another problem according to Dr. Tummon exists in the relationship where both people have genital herpes: "If each partner has recurrence once a month at different times, that means no intercourse for perhaps ten days, which means out of every month there are 20 days when they can't have a normal sexual relationship."

A person who is suffering an initial attack of genital herpes may complain of any or all of the following symptoms: general malaise, fever, lymphadenopathy (sore glands) and painful swelling of the genital area.<sup>3</sup> Transient blister-like sores and then characteristic ulcers will appear on the labia in women, and on the penis and scrotum in men. Urethritis commonly occurs, and voiding, especially for women, may be extremely painful and difficult. If urinary retention exists, patients may have to be hospitalized. 'Satellite lesions', blister sores similar to the ones found on the genital area, may appear on other parts of the patient's body.

### Treatment

It is an unfortunate fact that there is no real treatment for genital herpes — nothing works.<sup>4</sup> The best course at the moment is to treat the patient's symptoms which includes giving adequate analgesia, ASA for fever, and to recommend rest. Sitz baths may be suggested, and patients may benefit from being told to try voiding while sitting either in the Sitz or a tub bath of warm water. Under no circumstances should any steroid or anti-inflammatory preparations be used!

Doctors are researching new methods of treatment, but so far none has proved totally effective. One method involved applying ether to the herpes lesions, but patients concluded that the treatment was worse than the disease. Others have been trying light treatments, various cream preparations,<sup>5</sup> even contraceptive foam<sup>6</sup> but, as one doctor from the Centre for Disease Control in Atlanta wrote in the New England Journal of Medicine, "Every drug that has been subjected to a properly controlled trial in genital herpes has proved to be ineffective."<sup>7</sup>



Dr. Tummon cautions both nurses and doctors against being judgmental of genital herpes patients; they're suffering enough. He says the role of both nurses and physicians is to be supportive, well-informed, and to urge people to seek diagnosis and treatment as soon as possible when herpes first appears. ♡

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Jane Bock is an assistant editor at CNJ.

Gratefully acknowledged is the assistance of Dr. Ian Tummon, resident in gynecology at the University of Ottawa.

## VIRUS: Pirate in the body

What are viruses, and how do they differ from other disease-causing organisms? Why haven't scientists been able to find a 'cure' for the common cold?

Viruses are the smallest known living organisms; they affect plants, animals, and even bacteria to cause infectious diseases. They vary considerably in size and appear in various shapes but generally the viruses that affect man are spherical (see photo). Viruses that are agents of infectious disease are what is known as 'obligatory cellular diseases', which means that they cannot live and reproduce outside a cell.

The cells of plants and animals possess both RNA and DNA in their chromosomes — true viruses contain only one, either DNA or RNA.

#### Life cycle

When a virus invades the human body, it attacks and actually parasitizes a susceptible cell. The virus, which is enclosed by a protein coat, attaches itself to the cell and strips off its coat as it enters the host cell. What happens next is an act of piracy — the virus shanghai's the host cell into doing its metabolic work to form new virus particles. Because the virus has only one of DNA or RNA, the viral nucleic acid combines with the nucleic acid of the host cell; the virus can multiply only within the host cell. As a by-product of this process, the host cell is rendered immune — it cannot be reinfected by the same or related type of virus.

New viral particles are released, and groups of mature viruses escape from the host cell. For example, a host cell parasitized by poliovirus can produce 100,000 new poliovirus particles in a few hours. The new viruses can survive outside the cell until they reach new host cells, where the reproductive process once again begins.

#### Pathogenicity

The disease symptoms of viral invasion are the result of cell injury. Many viral infections are silent and show no signs of existence, while others, such as the herpes simplex virus, may be latent and appear or reappear long after the initial infection.

Some viruses can cause the host cells to reproduce in ways which are not normal cell reproduction, which gives rise to the theory that viruses are a possible cause of cancer. Of the 550 known viruses, approximately 200 cause 50 diseases in humans, some of which are extremely communicable and life-threatening.

#### Transmission

Viruses may spread from one human to another directly through contact, as in the herpes simplex virus, or indirectly in nose or throat secretions (the common cold), or in fecal material (hepatitis).

Other types of infection may be transmitted in water or food such as poliomyelitis and hepatitis, or by insects such as the mosquito which may carry equine encephalitis.

#### Immunity

After some types of viral infection, such as the diseases of childhood — mumps and measles — the human body develops a permanent immunity to the virus. For others, there is no immunity, as in the common cold. The mechanism by which the body resists viral infections is poorly understood, but involves a substance called *interferon*, which serves as a sort of blocking agent. Interferon actually stops the synthesis of the viral nucleic acid by some means; because of the theoretical importance of viruses in the development of cancer, cancer researchers are very interested in the action of interferon.

#### Prevention

Viruses can be destroyed by several other means: high heat for example, or formaldehyde, hydrochloric acid, elemental iodine, phenol, radiation and ultra-violet light all have some effect on various viruses. To prevent viral infection, normal methods of sterilization are effective — influenza viruses for instance can be simply washed off the hands with warm water and soap before they infect the body. Immunization is an important means to control viral infections such as measles, smallpox and polio.

Of great importance to all health professionals is the fact that except to treat bacterial complications that may be secondary to viral diseases, antibiotic or antimicrobial drugs have no effect on viruses.

Source: *Principles of microbiology* by Alice L. Smith, 8th ed., St. Louis, Mosby, 1977. pp.487-503.



A nurse's package of skills and knowledge has to be portable, as every nurse knows, and nothing is of more value in sorting out the chaos of a home care assignment than a basic nursing care plan.

# Nursing Care Plans and the Private Duty Home Care Patient

*Connie Eaton*

In the spring of this year I was summoned to my first private duty home care patient. Wearing a pale lemon-colored uniform, white stockings and sensible shoes, I sallied forth. I was pleased to be able to do some nursing on home ground, so to speak, even though my only information was my patient's name, age and phone number — it would be a bit like public health nursing, I thought, where one ventures out to make the kind of discoveries and observations that most people think only detectives are trained to do!

Armed with my purse and plastic shopping bag containing the agency's guidelines and policies, I arrived at the house — and found no one there! I am a fairly resourceful person and not one to give up easily, so I did what any normal public health nurse would do in such a situation: down the street I saw two women chatting and I decided to approach them about the use of a telephone, hoping at the same time that I might glean a little information about the house and family I was visiting. The women were discussing gardening as I approached, and apparently thought I was either a missionary or the Avon lady because they began to retreat to the house. I caught up with them and asked to use the telephone explaining that I was a registered nurse trying to locate a patient on the street. The one woman laughed then, saying it was obvious I was a nurse, intimating by her tone that no one else in their right mind would dress up in such a costume. I made two phone calls and was assured by my agency that I was indeed in the right place, that my patient was being delivered home shortly by her two sons after a visit to her doctor.



I returned to the house and introduced myself to the patient's sons who in turn introduced me to their mother. Another son and daughter-in-law arrived on the scene and before long all were talking and trying to put together the chain of events that had necessitated home nursing care and, in fact, crisis intervention. I admit to becoming a little confused trying to sort out the fragments of five people's conversation, and as it was by now supper time, things like 'Initial Assessment' and 'Nursing Objectives' seemed relatively unimportant next to the task at hand.

I did gather that my patient, Mrs. P., was 65 years old, that she had been a widow for just over a year and that she had one son living at home who needed to be fed daily on his return home from work. I also learned that my patient had been depressed for some time, had been self-administering a number of medications, had fallen at home the week before and again while out shopping a few days ago, thereby fracturing her jaw.

My patient and her son insisted on having steak cooked for dinner and so, not wanting to be disagreeable by wondering aloud how someone with a broken jaw could chew meat, I acquiesced. I decided to share the salad I had brought — spinach, tomatoes, mushrooms and cheese — with my patient, and I was not surprised to learn that she enjoyed it more than the meat. At least it was easier to chew!

Next came the business of sorting out my patient's medications, which made up quite an assortment: Aldactazide® 1 tablet daily, Lanoxin® 0.125 mg daily, Inderal® 1 tab. b.i.d., Cogentin® 1 tab. daily. There were immediate orders to discontinue the Cogentin, and to gradually reduce the Inderal over a period of several days. H.S. sedation was Nozinan® 12.5 mg and imipramine 50 mg.

Examining my patient's medication regime I was able to postulate that she had a heart condition, required a diuretic and a tranquillizer, an anti-depressant and an anti-Parkinson's agent. I thought that aside from giving the medications, my main duty with this patient would be to observe her, and attempt to help her meet basic human needs.



For instance, the family did not know when Mrs. P. had last had a bath. In any case, she did not want to have one, not that first night anyway, so I did not pursue the issue. As far as I was concerned, it would be best to wait until she indicated some willingness to have a bath, and that would be in her own good time.

Yet another problem was apparent from the beginning: the need to keep records. As there were to be nurses in the home around the clock, continuity of care was important, and this meant sharing information as to what kind of things were being done, with what responses from the patient. Given that Mrs. P.'s problems seemed to be predominately psychiatric in nature, this was of added importance.

But, as far as I could determine, the agency had no particular forms for medications, nursing progress notes or patient care plans. My responsibility to the agency was to submit a weekly progress summary and time sheet. I was provided with Guidelines for Home Care and a Code of Ethics...period.

My patient went to bed and while I sat in the adjoining sitting room to see that she did not get up unattended, I thought about the nursing challenge that this patient presented. Here was an opportunity for independent functioning, decision-making, and accountability — all dependent on the formulation of a patient care plan!

During the next several days, I made my observations of the patient and her situation prior to an assessment. I re-read the College of Nurses of Ontario's Standards for Nursing Practice and noticed the inclusion of a specimen patient care plan. Once I had the guidelines drawn up, I was able to quickly formulate a care plan for Mrs. P. The agency made several copies of this and none of the other nurses involved in Mrs. P.'s care had any alterations or counter-proposals to make.

Progress notes recording each day's activities had to be left in the home to be available to each nurse; this meant the notes were available to the family and the patient as well. I know that the family did read the notes since on one occasion someone corrected a spelling error and a fact of the patient's history — presumably to set us straight!

The total length of time this patient required home nursing care was five weeks; nurses wore street clothes when it was considered appropriate. The night shift was dispensed with after nine days and after four weeks only one nurse, working a split shift, was required for Mrs. P.'s care.

### **Realizing nursing objectives**

#### *Independence and autonomy*

From the second day of home care the patient was able to make decisions about meal planning and cooking, although initially with supervision. Her judgment regarding mobility however was poor and she had to be prevented from going down the basement steps alone. She needed constant reminding too to change her position slowly, as she experienced dizziness after moving quickly. Normally being a very independent lady, used to making her own decisions, it was important to reassure her that the nurses' watchfulness was not a reflection of her incapability, but rather a concern for her safety.

She had no recall of her accidental fall or injury; her memory began to improve after the tenth day and she began to ask questions about the experience. By the end of the second week of care she was able to write cheques and pay bills. She had made a hair appointment on her own by the third week, and assisted in baking at the end of the month. At this time too she initiated a visit to a friend's home, and was able to travel there and back on the bus, alone.

#### *Grooming and appearance*

At first, Mrs. P. had no interest in the selection of her clothes although she always commented on the nurses' clothing and appearance. She would put on a dress but without belt, and when the belt was located for her, she would fasten it in place with a paper clip. However, it was observed that whenever she was going to visit her doctor she made an extra effort with her appearance. Gradually she showed more interest in dress choice, and in applying light make-up. She was uninterested in looking at new clothes, saying "I can't be bothered."

#### *Appetite*

Regular, small attractive meals were planned daily for Mrs. P., using informal table settings in the kitchen. It was noted that she was more inclined to eat properly when she had company; her poor eating habits of the past few months were likely due to her depressed state and, more recently, to her constipation and lack of exercise. Roughage and fresh fruits were encouraged daily: prunes, whole grain cereals, fresh fruit and vegetables and plenty of fruit juice.

As the mother of a large family, it appeared she had always enjoyed being a provider of wholesome meals; she was less interested in providing for herself alone.

#### *Elimination*

Due to her memory loss, Mrs. P. had no recollection of the frequency of her bowel movements; she complained of abdominal fullness and nurses suspected she was impacted. We informed the physician on the second day and he ordered Dulcolax® suppositories which were not effective. On the fifth day he examined her and diagnosed a bowel impaction for which he ordered enemas. It wasn't really until the 11th day when preparation for a barium enema was given that her bowels started to move. She was finally started on Metamucil®, one tsp. daily in juice, to be taken until normal bowel function returned.

#### *Care of skin, nails and hair*

On the second day a tub bath was taken with supervision. As the patient was observed to have very dry skin, baths were taken subsequently every two to three days rather than daily. She accepted hair and scalp treatment for encrustation at the end of the first week, and required several more treatments. After this she preferred to go to her hairdresser. Her toenails had grown unchecked into large horny curved growths, and an appointment with a chiropodist was made.

#### *Sleep*

Mrs. P. had a history of a disturbed sleeping pattern for a number of years, and she tended to sleep a lot during the day. It was not possible to interest her in relaxation exercises, nor in quiet music or reading before bed. Various sedatives were prescribed for her by her psychiatrist, and she eventually settled on Dalmene® 15 mg which was at least helpful, if not totally effective. She said that noises outside disturbed her, or that she began "thinking of things", which interfered with her sleep. She was encouraged to sleep less during the day, and was happy with a rest on the bed.

#### *Activity and exercise*

Mrs. P. had always enjoyed the outdoors and walking, so accompanied walks were commenced by the fifth day of care. It was difficult to assess, bearing in mind her hypertension and irregular pulse rate, how much activity could be tolerated; she was not pushed, and gradually began to take longer walks each day, often with a purpose in mind such as visiting a friend, and she began to feel and look better.



## NURSING CARE PLAN

Needs	Problems	Nursing Actions	Expected Outcome
Independence and autonomy	-short term memory loss -physical weakness	Encourage participation in planning and care. Encourage independent action when ready.	increased independence (eg. unaccompanied outings)
Nutrition	loss of appetite due to depression	Use meals to structure day. Plan small, attractive meals of good nutritive value.	improved appetite better nutrition
Elimination	constipation and bowel impaction	Give medication as ordered by M.D. Encourage roughage etc. in diet, and exercise.	return to normal bowel function
Grooming and appearance: —skin —nails —hair	depression → neglect dry skin toe-nails overgrown neglect scalp encrustation	baths q2 or 3 days use of lotions, creams etc. good diet. make app't for chiropodist shampoos and oil massage	improved skin, and interest in personal hygiene patient responsible for regular hair care interest in appearance increases
Sleep	depression → disturbed sleep pattern	Give sedatives as ordered. Discourage sleep during day. Encourage physical activity.	
Exercise and activity	depression → loss of interest	Accompany on outings of increasing length. Encourage quiet purposeful activity.	improved general health and interest in external world
Depression	difficulty with expression of anxieties and sadness lead to inversion	Encourage gradual ventilation by establishment of trusting, friendly relationship.	return to self-sufficiency and interest in others.

### Depression

During the first two weeks, verbal communication was restricted to planning daily activities; her affect was mainly flat, her facial expression sad, and she looked extremely tired for a period of four weeks. Her level of communication varied with each of the nurses involved in her care, but gradually she began to express some of her feelings. She was concerned most about the recent deaths of three close family members, and agreed that she tended to "bottle things up" rather than share with her family. She said she had recognized some time ago that she needed help in coping with her situation, but was unable to make the effort. It was observed however that whenever members of her family asked how she was, she would quickly give a trivial answer and change the subject.

Her need for companionship was discussed and she recognized that the fact one son was living at home, although not often around to be company, meant she was not entirely alone at home. In a rare show of assertiveness, she said she was not prepared to wait on him hand and foot.

Mrs. P. was a challenging patient because it was readily apparent that while she would not likely change her lifestyle to any great extent, she needed some assistance to get her life back on the rails, as it were. While she could not change her personality to become more assertive, she was interested in learning more about her medical care at least.

### Signing off

I feel Mrs. P.'s case emphasizes several points about care of a patient within the home. First, rehabilitation of a patient tends to start immediately in familiar surroundings, and a patient seems able to function more independently in a familiar role. It is easier for the family too to take part in the care and rehabilitation process.

One might speculate too about the cost factor: in Mrs. P.'s case, her short term inability to care for herself and her depression might have required a stay in hospital, followed by a period of assisted care and rehabilitation. Home care in this case provided an economical and feasible alternative to institutionalization.

In any case, it is clear that in the situation where a private nursing agency does not provide guidelines as to goals and objectives in patient care, especially in the home, the basic Nursing Care Plan is of invaluable assistance to the nurse seeking to organize priorities of care. ♡

*Connie Eaton, R.N., has been nursing for more than thirty years since her graduation in Lancashire, England. Mrs. Eaton has lived in Canada since 1963 and has held a variety of positions ranging from public health nurse in Nova Scotia and Ontario to psychiatric staff nurse. She returned to England to practice nursing in the fall of 1979.*

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# HALO TRACTION

*Nelly York  
Deborah Cowan*

**Mrs. Stewart was a prime candidate for application of the halo cervical traction device. In the two months that she wore her tiara, we learned a lot about handling the special problems of patients who are in halo brace traction.**

Halo cervical traction is a device consisting of a circular metal band screwed into the skull to which metal rods are attached; the rods are attached to a cast or a jacket worn on the patient's trunk. The halo traction device provides rigid stabilization while allowing early mobilization, thus preventing many of the complications that result from the prolonged immobilization of orthopedic patients.

Halo traction is used for stabilization after:

- fusion of unstable cervical spine injuries secondary to trauma
- extensive fusion of cervical, thoracic or lumbar spine with associated scoliosis
- osteotomy and revision of previous spinal fusion sites
- Jefferson fracture
- fracture of the atlas
- decompressive laminectomy.

There may be variations in the halo apparatus in that it may be used with either a cast frame or a brace frame fitted over the trunk, and the frame may be extended to the pelvic girdle, depending on the area of the spine that requires stabilization. Basically however, the halo brace is as described briefly above: the aluminum 'tiara' is fixed to the cranium with four threaded pins, two anterior and two posterior. When the halo itself is tightened into position, the fitted brace is applied and positioned with the anterior and posterior rods which join laterally at the shoulder, and with the transverse rods which extend upward to join the halo (see photo); the rods may be adjusted in three directions.





Potential complications of use of this device include head pin migration in which one of the anchoring pins in the skull shifts in position and misalignment results, local infection at the pin sites, and paralysis due to pressure on the brachial nerve from the brace.

Nursing care involves positioning the patient in halo traction in such a way that there is no pressure exerted on either the rods or the ring of the halo. In addition, care must be taken to avoid hitting the rods with anything metallic, as the conduction of sound through the skull bones is quite uncomfortable.

#### CASE STUDY

##### *A candidate for the halo*

Mrs. Stewart, aged 60, was admitted walking to our nursing unit in January, with a provisional diagnosis of cervical myelopathy and instability associated with cervical spondylosis and Swan Neck deformity, S-shaped curvature of the cervical spine. It was noted in her history that she had had a decompressive cervical bilateral laminectomy with the removal of C5, C6, C7 spinous processes more than ten years previously for relief of a pain syndrome which involved her arms. In addition she had had enucleation of her right eye performed more than 30 years previously, due to glaucoma. She described a ten-year history of progressive neck pain and cervical fatigue with weakness and numbness in her legs.

Mrs. Stewart's presenting symptoms on admission were right leg numbness, a right foot which felt cool to touch, episodic right arm weakness with a limited range of motion, occasional dizziness and even "blackouts". Intermittent urinary incontinence was also a problem. She told the admitting nurse that her condition had become increasingly worse over the past three years.

Admission blood tests and urinalysis revealed results within normal limits, and after consultation with a neurosurgeon a cervical myelogram was ordered. Findings of radiological investigations of Mrs. Stewart's cervical spine were:

- narrowing of C5-6, C6-7, C7-T1 disc spaces with partial fusion of C6-7 and C7-T1

- narrowing of the anterior-posterior diameter at the C6-7 level and associated distortion of the spinal sac with the cord resting anteriorly against C5-6, C6-7
- cervical lordosis centered at C6
- degenerative disc disease detected at the lumbar-sacral level; possibly a factor in Mrs. Stewart's occasional urinary incontinence.

Together in consultation, the orthopedic and neurosurgeons went over Mrs. Stewart's history and test results, and confirmed her diagnosis as being a combination of cervical myelopathy aggravated by kyphosis, post-laminectomy kyphosis, and Swan Neck deformity which resulted in a kinking of the vertebral artery manifesting in dizziness.

#### Treatment

The doctors discussed their findings with Mrs. Stewart and she agreed to the course of treatment they recommended. This was to be two weeks of intermittent cervical traction to decrease the kyphosis followed by surgery to fuse anteriorly C5 to T1 with possible decompression of C5-6, and immobilization post-operatively.

Two weeks after admission, Mrs. Stewart's chest circumference was measured for her halo vest. Five pounds of cervical halter traction was applied, with four inch blocks placed under the bed to provide counter traction.

Nursing priorities at this time included teaching Mrs. Stewart the importance of lying flat while in traction, without pillows. 'Log-rolling' was used every two hours so we could give good skin care, and bony prominences were carefully observed for signs of pressure. In a cervical halter, these sites included her mandible, ears, and the sides and back of her head. The traction and weights were checked frequently to ensure proper alignment.

Mrs. Stewart was allowed to remove the halter at meal times when deep breathing and coughing routines were encouraged.

On the whole, Mrs. Stewart tolerated the cervical traction poorly due to increasing neck pain and severe

headaches. She asked for the halter to be removed often, and she required increasing amounts of analgesia. After five days, the doctors ordered the traction reduced to three pounds, but this gave only minimal relief of pain. After a week we began to ambulate her to promote lower limb strength and circulation pre-operatively. She continued to use the halter traction, but she was encouraged now to use pillows under her shoulders to hyperextend her neck. This measure provided comfort and actually maximized the effect of the traction on the cervical spine.

The doctors discussed the halo traction apparatus with both Mrs. Stewart and her family, and she decided to accept this form of treatment following surgery for cervical fusion.

#### *Wearing a halo*

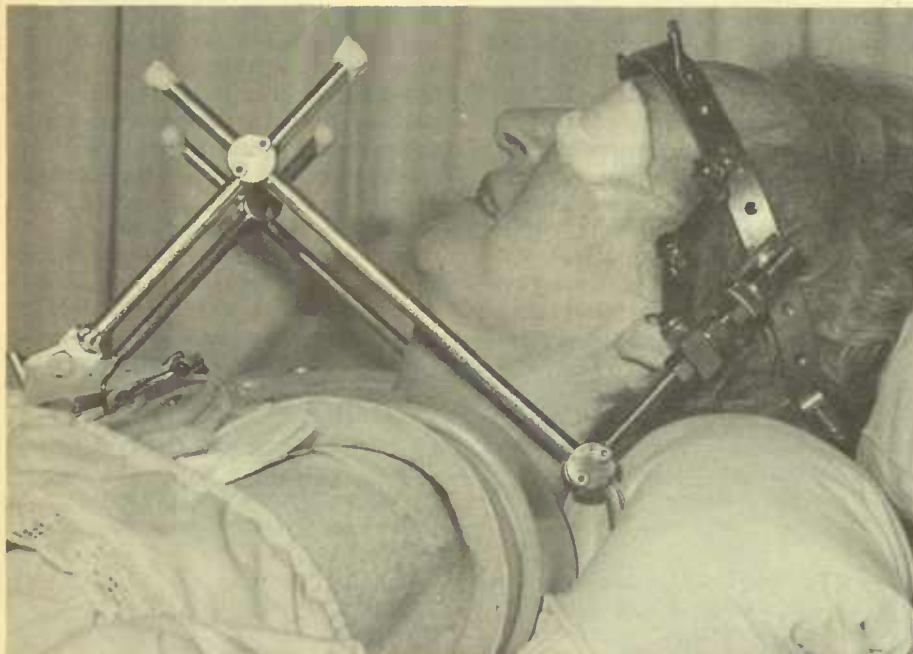
After nearly a month in hospital Mrs. Stewart went to the O.R. for application of the halo cervical traction under a local anesthetic. Seven pounds of traction were applied immediately, and increased to ten pounds the next day to increase neck extension.

Mrs. Stewart was now on complete bedrest and had folded towels and small pillows positioned behind her shoulders. Positioning the pillows was tricky: one was at the back of her neck and the other under her head, leaving space for the halo pins while at the same time preventing her head from resting on the bed. Counter traction was provided by elevating the head of the bed on four inch blocks.

We nursed Mrs. Stewart in the supine position at this time, log-rolling her for skin care and positioning her on her side for meals. The cervical traction was reduced after a time to seven pounds to prevent hyper-extension and to promote comfort. Two days before surgery the halo vest was applied and Mrs. Stewart was ambulated wearing the whole brace to familiarize her with the apparatus, and to decrease her anxiety.

The first week of February Mrs. Stewart underwent an anterior spinal fusion of C5-C6-C7 in the O.R., after which the halo cervical traction was reapplied. Traction weight was started at two pounds then increased to five and again to ten within hours.





Photos courtesy Educational Services, Calgary General Hospital.

#### *Post-op care*

Immediately after surgery, nursing care included frequent neurological assessments, checking for movement and sensation in Mrs. Stewart's extremities, and monitoring of her vital signs. Intravenous therapy was continued for three days post-op until Mrs. Stewart's oral fluid intake was adequate.

The third post-op day she began to complain of an extremely sore throat with a periodic "choking" sensation; a throat swab sent for culture and sensitivity and gram stain was negative, so she was treated symptomatically with elevation of the head of her bed 30 degrees, the use of throat lozenges, sips of fluids progressing to soft foods, and crushed or liquid medications.

Again, log-rolling was done every two hours for skin care routine and to allow for use of a slipper bedpan. Chest physiotherapy was being given at this time, and the nursing staff encouraged frequent deep breathing and coughing. Passive and active exercises were provided in order to maintain good circulation and muscle tone.

Mrs. Stewart was encouraged to drink 3000 cc's of fluids daily, and she required a bowel routine to prevent constipation.

The fourth post-operative day Mrs. Stewart's cervical traction was discontinued and the halo vest apparatus was reapplied and correctly adjusted.

#### *Convalescence*

Our patient was transferred to the convalescent rehabilitation unit for ambulation and preparation for the activities of daily living. Ambulation was initiated by providing proper positioning of Mrs. Stewart's head and neck while in a high Fowler's position in bed. From here she went to a high back recliner wheelchair (using a standing transfer method), with pillows to support her back, sides and arms. Initially she was up for just five minutes, but this was increased every two days by five to ten minutes, as tolerated. At first she found it uncomfortable to sit in the high



Fowler's position, due to the halo apparatus, but gradually her tolerance increased. With the use of supporting pillows she was eventually able to sit up for two hours at a time.

With the increased activity, Mrs. Stewart's previous bowel constipation became less of a problem. She started to use the commode chair too which ensured complete emptying of her bladder but she remained apprehensive about incontinence.

#### *Team nursing*

We held a team conference to discuss Mrs. Stewart's problems. In caring for her, we had ascertained that these included a difficulty with feeding, a need for increased ambulation, apprehension about urinary incontinence, and a need for some teaching about the care of her eye prosthesis. In addition, there was a problem with use of the bedpan, due to her fear of being incontinent; Mrs. Stewart would sit on the pan for long periods of time, and we feared that decubiti would result if this practice continued. During the day, we removed the bedpan from her reach, making it necessary for her to call for assistance. Then she was ambulated to a commode with two nurses helping.

We increased her walking time each day, and we used even short walks to the bathroom to progressively increase the amount of her activity. Gradually, as her strength and bladder control returned she was able to get up with only one person for support, and then by herself.

In order to assist Mrs. Stewart at feeding time and to help her regain her independence, we positioned her at mealtimes in the high Fowler's position and arranged her food tray so that all her food was in full view; she had difficulty drinking from a cup so we gave her a straw. Here too her strength and co-ordination increased, and soon she was virtually independent at meals.

Dressing was another problem for Mrs. Stewart, we knew, but fortunately she was able to obtain loose-necked nighties from her family, and later blouses, so that she could dress herself with a minimum of assistance. While the halo brace was in place, we used dry shampoo to keep her hair clean, and we

combed her hair for her. Skin care was a priority in our discussion as even with increased ambulation, Mrs. Stewart developed pressure sores on her scapulae which were relieved with the use of padding and skin ointment.

Physiotherapists were teaching Mrs. Stewart range of motion exercises for her arms, using the 'patient helper' for pull-ups and weight-lifting to increase arm muscle strength. She had a problem of tilting backward when walking which was corrected by the use of parallel bars and a mirror in the physiotherapy room. Nursing staff were aware of the physio program and reinforced the exercises and her need for correct posture whenever we ambulated our patient.

We discussed the Stewart family and their relationship to Mrs. Stewart; she had two sons and a daughter as well as her husband. Her family was very supportive and concerned about her health, visiting frequently. They were able to give her a good deal of stimulation by taking her for short trips to the hospital cafeteria, and touring other areas of the hospital. Near to the time of her discharge Mrs. Stewart was able to go out of the hospital on weekend passes to visit her son who lived in Calgary.

#### *Going home*

Nearly two months after the halo had been applied, Mrs. Stewart's halo brace traction was removed, and a fitted plastizode collar was put on in its place. Once the tiara was removed Mrs. Stewart was totally independent and able to walk with only a cane for assistance.

Teaching for discharge included instructions to avoid long rides in a car, not to do any lifting, and to generally beware of any flexion or extension of her spine. She was taught to turn her whole body instead of just her head, and to avoid any jerky movements. We asked her to continue to do her muscle-strengthening exercises and to watch her posture; she had to wear the cervical collar at all times, except when lying down, and she would have to keep it for three to six months.

Mrs. Stewart was discharged after 11 weeks in hospital and went to live with her son until she was well enough to make the trip home to her husband in B.C. We didn't see her again until the summer when she came in to see her doctor and she visited the unit where she had spent so long working toward her goal — she wore no collar and was happy, independent and strong. ✻

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**Nelly J. York, RN, and Deborah Cowan, RN, are staff nurses working on the orthopedic rehabilitation unit of the Calgary General Hospital. It has become apparent in their work that halo cervical traction is a device being used increasingly for immobilization in spinal injuries, and they hope their case study is of benefit to nurses across Canada. Deborah Cowan is a graduate of the Mount Royal College in Calgary, and Nelly York graduated from the Hotel Dieu Hospital, St. Joseph's School of Nursing, Kingston, Ontario.**



# IS THERE A MOVE IN YOUR FUTURE?



## Some practical tips on relocation — problems, pre-planning, where to stay and who to contact.

Laura Worthington

The law of supply and demand is an old one in the business world, well understood by financial analysts. It is only in the last year or two, however, that nurses across Canada have begun to realize how that law applies to them: too many nurses and not enough jobs! Sometimes, in order to remain in nursing, relocation seems to be the only answer.

Since my own move to California a year ago I have met and talked to a number of displaced Canadian nurses. My friendship with them and my growing familiarity with the health care scene in Los Angeles have influenced me to write

**POSTSCRIPT:** Canadian nurses now working or planning to work in the U.S. should be aware of recent changes in the U.S. Immigration Service which will require all foreign nurses (including Canadians) to pass the screening examination given by the Commission on Graduates of Foreign Nursing Schools. Filing deadline for the next CGFNS exam, in April, 1980, has been extended from January 2 to January 15, 1980. For more information, consult CGFNS, 3624 Market Street, Philadelphia, Pa. 19104 or your provincial nurses' associations. More details in next month's issue of CNJ.

this article, hoping it will facilitate the planning of anyone with relocation in mind.

### First the bad news

Let's face it: relocation is not for everyone. Many of the Canadians I've met in the past year are genuinely distressed by their move. Some of this unhappiness could have been avoided with a little self-insight.

If you love living in the Northwest Territories, love working in a 50-bed community hospital in the Canadian North, there is about an 80 per cent chance your move to "the biggest teaching hospital West of the Mississippi" will be a mistake. It may not, but chances are pretty good that it will. Stick with what you like. If a small-town flavor is for you, apply to community hospitals. Do you live for the first snowfall? Don't go to Palm Springs. How many times have I heard "but I miss the leaves turning color and the snow." Likewise if you come from a high powered teaching hospital in Toronto you may think that one-horse-town in Montana sounds wonderful. Better think again!

A unique environmental problem in Southern California is the lack of mass transit. You *must* be able to drive and have access to a car. It doesn't matter that the new hospital where you'll work is "five short miles from the beach". It might as well be 500 without a car.

And by the way, don't believe all you read in the ads about the attributes of a specific hospital. For example,

*Come work on our team. You'll love the true California quality of our locale. Minutes from the beach.*

One nurse who did believe a similar ad moved without a pre-visit, and ended up being very surprised. She got the large teaching center atmosphere she wanted. Unfortunately it was in a bad area of town, the beach was covered with oil riggings, and without a car, she was a captive in her hospital housing. There may be similar unique problems in the community where you wish to go. Do a little footwork and find them out before you arrive.

Patients in American hospitals have a different outlook on health care from that of their Canadian counterparts. Most people in the U.S. pay large sums of money for the health care they receive. This makes them consumers in the true sense of the word. Be prepared for detailed critiques of the food, furnishings and medical care. Naturally this is not true of all people and the situation is different at state-funded institutions. But it does happen and, if you're ready for it, the shock won't be so great.

### And now the good news

Whatever your personal reasons and thoughts on relocation, the good news is



that you will be received with open arms pretty much wherever you go. Los Angeles Sunday papers carry three or four pages of job ads for nurses every week. Some of the ploys the hospitals use to attract you are:

- **4-8-12 hour shifts.** You can pretty much choose but be prepared to start on nights. Many hospitals have this policy; to be sure, *ask* what shifts are available to new hires.
- **20 per cent shift differential** for night work; 15 per cent shift differential for PM work.
- **application to a specific hospital** may net you:
  - a round trip ticket for an onsite visit (especially if you have a specialty or management skill).
  - expedition of your visa by the hospital *after* you have signed on.
  - provision for interim housing after you arrive at your new job.

### Pre-Planning

Is a move part of your career future? Start planning now! There are lots of things to learn and do before you consider going anywhere.

#### 1. Finances

If you have just enough money in your pocket to get to your new destination, don't go! Relocating is filled with hidden expenses. Most apartment owners in big cities require first and last month's rent *in cash* plus a cleaning deposit. In the beach communities of Southern California that means: \$300 (rent per month, one bedroom) x 2 (first and last) + \$50 (cleaning deposit). This translates into \$650 that the manager expects *in cash* or money order unless you already have your new bank account. (Don't count on that, it takes longer than you think. See below.)

Having your Canadian bank wire money to the new U.S. one is a safe way of money transferral. However it is *not* as speedy as bank officials may claim. I was nearly evicted from my brand new San Francisco apartment because the money I had wired from Vancouver didn't arrive at my new bank in time. Would-be landlords are not impressed when your first cheque "bounces".

Do wire large amounts of money. But be sure to take sufficient travellers cheques with you to cover expenses within the first month of your move.

#### 2. A place to lay your head

Nothing is worse than arriving in a strange town and not knowing where to stay your first night. So arrange this in advance.

Staying at reasonable accommodations for a week or two allows you to see the city leisurely before you decide on a place to live. The

YWCA (or YMCA) is always a cheap and usually a good choice. Most Y's are situated in the city center which allows you to immediately get acquainted with your new environs. The only drawback to this arrangement is that some YWCA's are in the seedier area of downtown.

If the YWCA isn't your style, try writing to the department of tourism (or city hall if it's a small town) in the city you've chosen and ask for hotel information. This should help you select your first accommodation.

#### 5. Who to contact

You *must* contact the nursing association in the state where you propose to go: through them you will learn about state licensure requirements. Obviously this is something you do in your planning stage. Be sure the state accepts your provincial license; if it does not you may be required to take the national boards exams in the U.S. and/or repeat certain parts of your clinical training. (i.e. pediatrics, public health, psychiatry). And when you arrive all set to work, but without a license to practice, this can be very upsetting.

#### 3. A pre-move visit

As I've mentioned, writing ahead to the hospital or hospitals of your choice may net you a round trip onsite visit; even if it doesn't, you should try to go see your new locale before you actually move. I knew a nurse who left the "mainland" to go to Hawaii for an excellent job in nursing. This nurse "just knew" she would love it there. Unfortunately she and her 4,000 pounds of furniture returned three weeks later because things weren't all she had expected. Save yourself that expense — a pre-move visit is a crucial step in planning.

Another way of doing this is to attend a medical conference in the city of your choice; this gives you a preview of what you can expect. You get to see the area and rub shoulders with some of your future colleagues. Initial work contacts can be made at this time too. One side benefit — the trip is tax deductible if the conference furthers your profession.

#### 4. Visas

Arranging for a work visa in the U.S. takes a little time since nurses along with everyone else are subject to the quota system. To start the wheels turning, visit or write the American Embassy nearest you. If your pre-trip visit has already helped you select a hospital and you have been assured employment there, this can expedite matters. Most nurse recruiting departments in the U.S. are able to help you obtain a work visa and entry papers. It is accepted practice for them to expect you to sign a work contract at that time.

The American Hospital Association can supply you with the names of teaching and non-teaching facilities across the nation. You can learn from them the size of the hospital, whether it is an acute care facility, and its location.

**State**  
Board of Registered Nursing  
1020 N Street  
Sacramento, Calif. 95814

#### National

American Hospital Association  
840 N. Lakeshore Dr.  
Chicago, Illinois 60611

Once you have the names of the hospitals in your new locale you can make another contact: the nurse recruiter. She will be someone with whom you can correspond prior to your onsite visit. Through this correspondence you can set up an interview date, which saves time when you do arrive in town. Your nurse recruiter will also often get you a packet of information about the hospitals you are interested in before you arrive. This can be a big help in deciding where to work.

And last but not least, if you correspond with her, the nurse recruiter may agree to provide you with references. When you "don't know a soul" and everyone from the telephone company to the landlord wants an in-town reference, this can be invaluable.

#### Conclusion

Whatever your reasons, relocation should be the best move you can make. And, if you know what you want and how to get it, it *will* be. I hope this article helps you toward that goal. ♡

**Laura Worthington**, the author of "Is there a move in your future?", is a Canadian nurse now working in the United States where she is employed by Cedars-Sinai Medical Center in Los Angeles as coordinator of their critical care programs.

Three years ago, when she represented the Canadian Nurses Association at that year's International Conference on Medical Devices in Ottawa, her report was featured in the October 1977 issue of the *Canadian Nurse Journal*.

Before moving to California, Worthington was nurse clinician in the recovery room and ICU of the Royal Victoria Hospital in Montreal. A graduate of the University of San Francisco and of the University of California, where she received her Master of Science in cardiopulmonary medicine, she has worked in intensive care units across Canada and the U.S.



# The expanded role of the handmaiden

Jo Logan

**Is equality among our fellow workers destined to be the chimera of the nursing profession? Always just beyond our grasp? Not content merely to serve the doctor, the nurse has now expanded her handmaiden role to include the pharmacist, social worker, physiotherapist, occupational therapist, dietician...in fact, most of the people she works with.**

**Why? And what to do about it? Is education the answer? Perhaps the only answer? I believe it is.**

The role of doctor's handmaiden had some advantages for the nurse: everyone knew that a good handmaiden was worth her weight in gold.<sup>1</sup> But times have changed, as have health care needs, the educational preparation of other health disciplines and the nature of nursing. For awhile it seemed that nursing did not want to fulfill the handmaiden role any longer, opting instead for a more independent role in the health field. But now it looks as though, as a group, nurses are choosing to function as handmaidens after all. Of course, in order to meet current demands, the handmaiden role is expanding: nurses are now providing this service to *all* members of the health team.

This has come about because, of all the members of the team responsible for direct patient care, the nurse is the least educated. As such, she is subject to pressures from outside the profession which distract her from practicing in a way that is congruent with current nursing expectations. Today's nurse is, in fact, inadequately educated to undertake the activities required by modern health care standards.

How can the nurse be considered a professional colleague and an equally contributing member of the health team when the disparity in their educational preparation is so obvious? Doctors, dieticians, physiotherapists, occupational therapists, pharmacists or social workers are all educated in a university. Even technologists prepared at community colleges consider their three-year program superior to most nursing education programs and, of course, three years concentration on one system *does* provide a depth of knowledge impossible to acquire in a two-year course designed to teach humanistic care for a patient who possibly harbors multisystem problems.

There are some within these groups who think that nursing consists of changing soiled linen and believe therefore that present nursing education is adequate. In my opinion, based on what I witness in my work, nurses do not have any less critical or complex decisions to make than many of these other professionals. Nursing assessments save lives!

I am tired of hearing from detractors of nursing. There are some uncaring and incompetent nurses in the field but there are also many excellent nurses. Given their education and the demands of current health care, it is a wonder nurses succeed in meeting any patient needs at all. Consider what a nurse is expected to accomplish on a medical or surgical ward on an average evening shift:

- juggle the demands of families, doctors and other personnel, all of whom have a "me first" attitude

- coordinate the activities of all her so-called "colleagues"
- and, almost as an afterthought, plan, implement and evaluate care for each and every individual patient in her charge.

I do not believe that the service provided by nurses is so inconsequential that the educational preparation can afford to be limited.

The magnitude of that which nurses face daily is such that they often appear incompetent. This situation is frequently exacerbated because other groups tend to judge nurses by criteria from their own discipline: nurses do not know as much medicine as doctors, nurses do not know as much about nutrition as dieticians. They do not even know as much about respiratory technology as members of this group. The conclusion is that nurses do not know very much about anything at all and must be carefully directed; direction is required not only on how to implement the orders from other disciplines but also on how to function in the area some of us still think of as nursing. I have heard a physiotherapist, for example, remind an experienced surgical nurse to be sure to let the patient sit on the side of the bed for a few minutes before getting up for the first time. The nurse smiled graciously if a touch wearily. I have also heard a respiratory technologist vehemently insist on a nurse giving comfort to a family member; the hassled nurse declined because she knew that particular visitor had absolutely no connection with her deceased patient. The range of guidance seen as necessary for nurses extends from simple physical assessment to complex psychosocial interventions.

Nurses not only serve as handmaidens, they also make convenient scapegoats. Errors in patient care have increased along with the number of care providers. That nurses should be held accountable for the mistakes of other groups is one of the myths by which we all live. The nurse is the patient's last line of defence: she is the final safety filter for any patient therapy. This puts the nurse in a position where she must act as an expert in every discipline, plus her own. Impossible!

Unless the nursing profession is going to be content to restrict its practice to carrying out delegated functions for other groups, we must educate all of our members to a professional level. If we do not, the plans of nursing educators and administrators for a profession comprised of members able to use nursing process with consummate skill will never materialize; nursing process is still a fragile concept, easily destroyed as real nursing is continuously subordinated to the demands of others.

If basic preparation provided the expertise necessary to practice in the manner nurses think appropriate, nursing would be in a better position to withstand the distractions created by others. Nursing education does not now provide the skills and in-depth knowledge nurses need when expectations "...include knowledge and skill related to the assessment, planning, implementation and evaluation of nursing problems in both social-psychological and physiological realms."<sup>2</sup> Many studies have tried to determine why nurses do not consistently use care planning in their practice. One conclusion is that they lack the necessary theoretical knowledge.<sup>3</sup>

As nursing research becomes more clinically oriented, it creates a science of nursing; nursing students will have to learn new concepts which must be incorporated into existing practice. In addition, utilizing concepts from other sciences will continue to be a necessity for nurses. Although nursing reflects the contemporary focus on health, the ability to care for patients in acute care agencies will always be essential. How long does it take to learn the knowledge, skills and attitudes required by existing nursing standards? Whether operating in a community milieu, in the mechanized world of critical care or elsewhere on the continuum, nursing must provide more depth and sophistication to the education of the new practitioner.

We have failed in our attempt to provide two levels of registered nurse practice. Nurses in North America are no longer committed to dividing nursing practice into two groups:



the so-called professional/technical split. The professional and technical functions of the nurse can be separated in a classroom but not while giving care to a patient. McClure laid bare this issue with decisive clarity, describing the technical functions as an integral part of professional nursing practice.<sup>4</sup> Schlotfeldt agreed, stating that "...technology is an important aspect of all professional practice and professional practitioners are expected to be highly competent, technically."<sup>5</sup>

Both diploma and degree programs of nursing education have been accused of failing to produce a graduate with sufficient technical expertise. To pit one type of program against another is futile; each was right for its time but that time is past. The question now is: how long can experienced nurses continue to bridge the ever widening gap between their educational preparation and the demands made upon them? How will each succeeding year of graduates cope? Can a new graduate realistically be expected to manage her own increasing responsibilities as well as those imposed upon her by others? The nurse educator's lament that nursing administration expects too much will grow to a wail as nursing administration valiantly tries to keep afloat amid the financial constraints and empire building now in vogue in many agencies.

None of this is to be interpreted as a vindication of some previously existing program or as testimony that people with university educations are superior people to those with diploma or community college credentials! I know that the level of care nurses give depends on many things, however, I feel strongly that education is one variable over which nurses exercise control as a method of defending and strengthening their profession. Nurses without university preparation are having to utilize every possible means to fill in the gaps in their education and acquire new expertise: many use formal continuing educational programs as a method of development; others solve the frustrating problems of work by escaping to a university setting, choosing a nursing degree in the hope that it will lead them away from the bedside. A more serious loss to clinical nursing is the brain drain of nurses who prefer a professional career in some other field.

University nurses from generic programs present another problem: there are those within this group who clearly and frequently proclaim their superiority over other nurses. This denigration of one nurse by another is destructive and more offensive than disparagement by other professionals. Paradoxically, these are the very nurses who fail to realize that all nurses are perceived as being the same regardless of education or experience.

Basic nursing education must move towards a solution to these problems. There must be a shift from the community college to the university. But, if currently registered nurses regard such a change in educational preparation as a threat rather than a necessity for practice and survival, this change will be slow to happen. The decision is whether to settle for an

expanded handmaiden role or to strive to achieve a professional role for all nurses; there cannot be two groups of registered nurses. We must explore flexible approaches to adding to the educational base of each individual. At the same time, we must determine methods of providing security for current registrants. This is a more valuable use of energy than opposition to such a desperately needed change.

University faculties will have the task of designing a curriculum which meets the standards of the real world. Inherent in this change is provision for articulating interested registered nurses into the university and supplying encouragement for them to do so. A realistic program for the education of all nurses will provide practitioners with the expertise to cope with new frontiers of knowledge in all the sciences and the concomitant increase in legal and ethical issues. Unified preparation will also provide the professional solidarity that is needed for a viable support system.

Community college faculties should assume more responsibility in several areas of nursing. Expanding their continuing education services would provide all practitioners with the information and skills to prevent obsolescence. The need for refresher courses will increase as nurses continue to drop temporarily out of clinical practice and as licensing regulations become more rigorous. Community colleges should specialize in nursing other than that given at the graduate university level. Smoyak states that "specialization is the inevitable result of new knowledge within fields and demands from the public for new services."<sup>6</sup> As medicine becomes more specialized, nursing must become likewise specialized; every time a doctor initiates a new therapy or surgical procedure, a nurse must be present to give expert care, whether the focus is on cure or helping the patient to cope.

The nursing profession in Canada can forestall disaster and diminish the external pressures that now threaten the profession by making some crucial decisions about educational preparation. Nurses need to be better prepared; when their level of expertise rises, nurses will be able to resist the handmaiden syndrome. As an educator, I would rather teach a nurse to write and implement nursing orders than teach her to carry out the directions of a multivariate group of professionals and para-professionals.

The nursing role is expanding but, unless the profession educates its people to a sufficient level, nurses functioning in this expanded role will grow increasingly subservient, and nursing as a profession will never live up to its potential. ♡

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# UNIVERSITY PROGRAMS FOR RN'S

Going back to school need not be drudgery: nursing programs today offer a wide variety of courses covering many interests as well as the core nursing subjects — literature, philosophy, sociology — all these are available.

For the RN who is interested in upgrading her educational qualifications, CNJ has compiled a catalogue of programs — both degree and certificate — available in universities across Canada. Of special note is the number of universities now offering part-time study.

Interested nurses should write to the institution of their choice for a calendar and further information, and apply *early*. It is a good idea too to enclose with the application a thorough resume of past education and experience.

Good luck!

UNIVERSITY	DEAN	PROGRAMS FOR REGISTERED NURSES	POST-GRADUATE PROGRAMS
Alberta, University of  Room 3 - 118 Clinical Sciences Bldg. Edmonton, Alta. T6G 2G3	Amy E. Zelmer, PhD  <i>Deadline for application May 15</i>	<b>BScN</b> —2 years (to be completed within 5 years of admission, one year must be full-time)  Adv. Practical Obstetrics — 1 calendar year  Nurse-practitioner orientation period plus 4 months clinical experience  Despite a policy to support university level nursing programs, the Government of Alberta has refused to fund expansion at the University of Alberta.	<b>MN</b> 2 years (in acute illness)  <b>M.Ed.</b> <b>MA</b> 2 years, <b>M.Sc</b> ) not offered by Faculty of Nursing  <b>M.H.S.A.</b> Master of Health Services Admin. 2 years  diploma in Health Services Administration
British Columbia, University of  2075 Wesbrook Mall Vancouver, B.C. V6T 1W5	Marilyn D. Willman, PhD	<b>BSN</b> —one summer course (May, June, July) followed by 2 years	<b>MSN</b> 2 years  <b>M.Sc</b> (Health Services Planning) 2 years  <b>MA and M.Ed.</b> 1 year <b>EdD</b> — 2 years
Calgary, University of  2920 24th Ave. N.W. Calgary, Alta. T2N 1N4	Margaret Scott-Wright, PhD  <i>Deadline for application April 1st</i>	<b>BScN</b> <b>BN</b> — 2 years  Note: certain courses taken at Athabasca University in Edmonton are acceptable toward a post-RN degree. For more information, contact Athabasca University, Box 10001, Edmonton, Alta., T5J 2P4.	



UNIVERSITY	DEAN	PROGRAMS FOR REGISTERED NURSES	POST-GRADUATE PROGRAMS
<p>Concordia University</p> <p>7141 Sherbrooke St. West Montréal, P.Q. H4B 1R6</p>	<p>Muriel Uprichard, PhD Director Health Ed</p>	<p><b>BA</b>—specialization in community nursing — 90 credits</p> <p>Certificate community nursing 45 credits</p> <p>Certificate health education 45 credits</p>	
<p>Dalhousie University</p> <p>Halifax, N.S. B3H 4N8</p>	<p>Margaret L. Bradley director School of Nursing</p>	<p><b>BN</b>—3 years — part-time study possible</p> <p>Outpost and Public Health Nsg 15 months (one year + 28 wk internship in North)</p>	<p><b>MN</b> — 1 calendar year</p>
<p>Lakehead University</p> <p>Thunder Bay, Ont. P7B 5E1</p>	<p>Margaret Page director School of Nursing</p>	<p><b>Honors BScN</b>—4 years — RN's may challenge certain courses for credit.</p>	
<p>Laurentian University</p> <p>Ramsey Lake Rd. Sudbury, Ont. P3E 2C6</p> <p>*courses available in French</p>	<p>Wendy J. Gerhard director School of Nursing</p> <p><i>Correspond before August 1980</i></p>	<p><b>BScN</b>—2-3 years, depending on success of student in challenge exams taken after 1 year of study in nursing, science, social sciences and humanities.</p> <p>—some part-time courses available: also in North Bay, Kirkland Lake and New Liskeard through colleges</p>	
<p>McGill University</p> <p>3506 University Street Montréal, P.Q. H3A 2A7</p>	<p>Joan M. Gilchrist director School of Nursing</p>	<p><b>BScN</b>—3 years (RN's with diplomas from hospital schools may have to make up some sciences)</p>	<p><b>M.Sc.</b> (applied) 2 years</p> <p><b>M.Sc.</b> (applied) for non-nurses with a BA or B.Sc. 2 years plus preceding qualifying year</p>
<p>McMaster University</p> <p>Health Sciences Centre 1200 Main Street W. Hamilton, Ont. L8S 4J9</p>		<p><b>M.H.Sc.</b>—3 academic terms, full-time —applicants assessed individually; baccalaureate degree not necessarily required, but applicants must have successfully completed some university credit courses and have at least 2 years clinical practice. Write: Graduate Program Office, Rm. 3N8</p> <p>Primary Care Nurse Program — 1 academic year —leads to diploma in Primary Care Nursing —combination of practice and study</p>	
<p>Manitoba, University of</p> <p>Winnipeg, Manitoba R3T 2N2</p>	<p>June M. Bradley assoc. professor and acting director</p>	<p><b>BN</b>—4 years RN's may challenge courses for credit in 1st, 2nd and 3rd years of program.</p>	<p><b>MN</b> 2 years — clinical specialization community health nursing</p>



UNIVERSITY	DEAN	PROGRAMS FOR REGISTERED NURSES	POST-GRADUATE PROGRAMS
Memorial University of Newfoundland  St. John's, Nfld. A1C 5S7	Margaret D. McLean director School of Nursing	<b>BN</b> (post-RN) — RN's are granted 15 non-specified credits on admission. Program is 6 to 7 semesters  Diploma in Mental Health and psychiatric nursing —2 semesters plus clinical experience  Diploma in community health nursing —2 semesters plus clinical experience  Degree and/or diploma program in Midwifery and Outpost Nursing —8 semesters or 3 years, 5 semesters or 2 years, respectively	
New Brunswick, University of  Fredericton, N.B. E3B 5A3	Irène Leckie	<b>BN</b> —3 years (RN's join basic students after 1st year) —part-time study available.	
Ottawa, University of  Ottawa, Ontario K1N 6N5	Marie des Anges Loyer director Faculty of Health Sciences  <i>Deadline for application June 1</i>	<b>BScN</b> —3 years. *courses have changed, check 80-81 calendar —may be taken part-time; courses must be completed within 8 years of start	<b>M.H.A.</b> — Health administration 2 years
Queen's University  Kingston, Ontario K7L 3N6	Alice J. Baumgart	<b>BScN</b> —Basic program is 4 years; RN's may receive some credit for 1st and 2nd year courses	
St. Francis Xavier University  Antigonish, N.S. B2G 1C0	Ellen Murphy chairman Dept. of Nursing	<b>BScN</b> —3 years	
Saskatchewan, University of  Saskatoon, Sask. S7N 0W0	Hester J. Kernan	<b>BSN</b> —15 credits, 3 years (up to 9 courses available through University of Regina)  —up to 2/3 of the program may be taken in Regina through University of Regina	Diploma in continuing education — 1 year  <b>M.C.Ed.</b> — 1 year plus thesis  <b>M.Ed.</b> in continuing education — 1 year plus thesis, or 2 full years
Toronto, University of  50 St. George St. Toronto, Ontario M5S 1A1	Phyllis Jones	<b>BScN</b> —3 years first and second years are available on a part-time basis through Woodsworth College to graduates of diploma nursing school only	<b>MScN</b> — 2 years, focus on clinical specialization and research
Victoria, University of  P.O. Box 1700 Victoria, B.C. V8W 2Y2	Dorothy J. Kergin, PhD Associate dean Health Sciences  <i>Deadline for application January 31st</i>	<b>BSN</b> —2 years full-time, or up to 6 years part-time (with at least one full-time year)	



UNIVERSITY	DEAN	PROGRAMS FOR REGISTERED NURSES	POST-GRADUATE PROGRAMS
Western Ontario, University of  London, Ontario N6A 5C1	Beverlee Cox, PhD  <i>Deadline for application May 1st</i>	<b>BScN</b> —3 years (may be taken part-time)	<b>MScN</b> (administration) 1 calendar year  <b>MScN</b> (education) 1 calendar year
Windsor, University of  Windsor, Ontario N9B 3P4	Anna Temple	<b>BScN</b> —3 years  Diploma in public health nursing — 1 academic year may be done part-time, finish within 5 years of start	
<b>FRENCH-LANGUAGE UNIVERSITIES</b>			
Laval, Université  Cité universitaire Québec, P.Q. G1K 7P4	Thérèse Fortier	<b>B.Sc.Inf</b> —3 ans	
Moncton, Université de  Moncton, N.B. E1A 3E9	Marcelle Dumont	<b>B.Sc.Inf</b> Le programme d'intégration pour les infirmières autorisées peut se faire à plein temps—deux ans—ou à temps partiel.	
Montréal, Université de  Case postale 6128 Succursale 'H' Montréal, P.Q. H3C 3J7	Diane Goyette	<b>B.Sc.inf</b> —3 ans	
Québec, Université du  Trois Rivières, P.Q. G9A 5H7  Chicoutimi, P.Q. G7H 2B1  300 Ave des Ursulines Rimouski, P.Q. G5L 3A1  Case postale 1250 Succursale 'B' Hull, P.Q. J8X 3X7	Louise Migneron  Brenda Dutil  Denis Rajotte  Fernande Viens	<b>BScN</b> —3 ans  <b>BScN</b> —3 ans  <b>BScN</b> —temps partiel  <b>B.Sc.Inf</b> —plein temps ou temps partiel	
Sherbrooke, Université de  Centre Hospitalier Universitaire Sherbrooke, P.Q. J1K 5N4  *voir aussi Laurentian University, Sudbury	Denise Lalancette	<b>BScN</b> —90 crédits	



# Do say!

## an essay on motivation

Brian Cristall

***"And when you have determined what is to be done under the circumstances, still you will usually have no power to compel the necessary course of conduct, except through those motives to action which are consonant with the hopes, the fears, the prejudices of your patient...you must be able to judge quickly as to these motives. This judgment can only be founded on a thorough knowledge of human nature, and this knowledge and the use of it, therefore, constitute important elements of professional skill and tact."***

- Thomas Laycock (1812-1876)

Recently, I was asked by the supervisor of the public health nurses in my community to give a lecture on motivation. I was very reluctant to do so because motivation is such a large and general topic, but she explained to me that what the PHN's were interested in was the question of how to motivate their patients. I began to search for an answer, but after a short while came to the frightening conclusion that I didn't have any answers to this question and therefore couldn't possibly give the nurses a lecture. I told this to the supervisor.

"That's good," she said, and went on to say that she expected my presentation in two weeks.

Perhaps that's an important way of motivating people, I thought: don't let them think about what you're asking, just tell them to do it and perhaps they will. But there had to be more to it than that. What she did that was even more powerful as a motivating force was to let me know she believed I could give such a lecture, when I had been wallowing in uncertainty. I went on to prepare the lecture because I felt better having her confidence in me. *People have to believe they can do what is asked of them.*

Obviously, there is a great deal to motivating people, more than the two suggestions I have made, and neither of these is very helpful to the nurse who wants an answer to the question, "How can I best motivate someone?"

One can easily understand the nurse's preoccupation with motivation and the facilitation of change. Nurses are constantly looking for solutions to the problems people present in their work.

It is important though for anyone involved in helping other people to acknowledge just how dependent any therapist is on being able to come up with solutions; a lot of anyone's self-worth is tied up in being able to do something concrete to help. Problems without solutions tend to make a person feel inadequate.

A tentative answer then to the question, how can I help, might be simply 'listen to your patient'. And by this I mean *really* listen, and hear what the person is saying to you. Listen to the problems that are very real to that individual, to the sadness and helplessness they feel. But remember — it is not your responsibility to decide what that person should do, or where he should go.



Once you understand this, you have grasped the fundamental truth, that you cannot in fact motivate anybody to do anything, you can only allow them to motivate themselves.

You have no power to 'cure' anyone of his problems, and indeed it is an interesting paradox that when you try to motivate someone to change, you end up actually interfering with his natural motivating forces. If you start believing, as a patient or his family might, that you have the power to motivate or to change them, then you are getting trapped by the people you are working with. Understand for instance the message you might get from a distraught mother: "My world is broken and only you can fix it." Not true. Only the mother can fix it, only the mother has the motive power to repair her own life.

Listening to people will provide you with clues as to what is wrong with their own strength of will; you will hear in their stories about the conflict and fear of change: "I can't do that, I've never done that." Active listening is the key to basic contact with another person, and honest and genuine response is another.

There is no one response that will fit every patient; one must respond differently to different people, and even at different times with the same person. There is no right or wrong response either, there is only a response that is the result of sensitive listening. If someone's problem is such that you can't offer any help, say that, share that fact with the person. It may be a relief for him to hear that a professional doesn't know what to do either.

Any individual in a helping profession has a most difficult task. We must work with multi-problem situations and families where the very real economic and social realities are such that the problems are probably impossible to solve. If a fourteen-year-old native girl's father ran away with another woman, and her mother was a drunk; if men take advantage of her sexually and beat her to relieve frustrations, then we have a very real problem but one that's impossible to solve. There's nothing that you can do to change the economic and social realities. But you can make the kind of basic contact with the native girl which will allow that girl to explore her life's story, and come to accept the fact that life dealt her a bad hand; that's rough, but that's it. Only by establishing the kind of human contact in which the girl can safely explore her feelings toward her horror story, will she ever be able to begin to make the kind of changes necessary for her to find fulfillment in her life.

But the motive power for change and for working against these very bad odds must come from within that girl and can never come from the outside.

What I have been saying then is not that there are ways to motivate people, but that there are ways for a professional person to help people motivate themselves. In relating to a patient you do one of three things: you either motivate them, do absolutely nothing for them, or you actually block their motivation. To understand this, it is helpful for nurses to know what kind of things contribute to health care workers' blocking patients' motivation.

- **Values.** Many professionals find the personal values of the people they work with vary greatly from their own. An example: you enter a house for the first time and you find a filthy mess. The dishes are dirty, clothes are scattered everywhere, and the baby's diapers are full. You think: this house is a mess, how do I motivate this woman to get this place cleaned up? But the dirty house isn't her problem, it's *your* problem.

- **Culture.** Nurses and other professional workers come most often from middle class backgrounds and are unable to understand the characteristics and pressures existing in other social groups.

- **Sensitivity.** Unlike psychotherapists in private practice, health care workers cannot choose the people they work with, and they cannot be sensitive to all the people they come in contact with.

- **Expert whiplash.** Many of one's clients or patients will have had numerous experiences with experts or professionals and may have had bad experiences, making them less cooperative.

- **The "I'll help you" hang-up.** Many workers unconsciously display an attitude that says let me rescue you, which is in essence a top dog-underdog situation, with the professional having the upper hand. In this situation, the underdog may win by not being helped.

All of these are important factors to remember, as is the idea mentioned before that health care workers often have a great deal of their own personality invested in coming up with a solution for people. If you find yourself giving lots of advice instead of really listening and responding genuinely, it's a certainty the patient's motivation is being blocked.

Back at the beginning of this article I said that nurses usually want to know, "How can I motivate someone?" And my answer to that is, you can't. The question is all wrong; when you ask 'how can I...' you are taking responsibility for your patient, and that's the first wrong move.

Well, you ask, how can a nurse be of any use? How can a nurse in hospital motivate the patient with an ileostomy to learn how to use his appliance himself? How can the community health nurse whose diabetic patient is still dependent on her persuade that patient to give his own injections? What to do?

The nurse can be helpful in many ways, not the least of which is just being there. You are another human being capable of the same emotions and subject to the same stresses as your patient. You can provide the acceptance and support that nurtures motivation and personal growth, and you can listen actively and with purpose.

While it would seem there isn't any magic answer to the problem, there is one word that describes the nurse's role here: that word is "Caring". Knowledge and technical skills are all very well, but without real personal caring there is no power in them. As long as one chooses always those actions which reflect caring, one cannot go wrong.

As Don Juan tells Carlos in 'Journey to Ixtlan', "All paths lead to the same place, and that's nowhere, so always follow the path with a heart." ❖

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# The integration syndrome

Mohamed H. Rajabally

This year, after almost a decade of co-operative planning and preparation, the Canadian Nurses Association (CNA) will introduce its new comprehensive examination for nurse registration. (See *The Canadian Nurse*, May, 1979). As a result of this commendable achievement, Canada will become the first nation in the world to implement a nursing examination of this nature for persons wishing to enter the profession. Obviously, the leaders of Canadian nurses know something that their American counterparts do not.

Underlying introduction of the comprehensive examination is the rationale that change in our present system of examinations is necessary in order to keep pace with the changes that are taking place in nursing education. These changes have occurred because of the movement in recent years towards integrating nursing programs and the preparation of general practitioners at the basic level. The comprehensive examination will permit the national Testing Service for beginning practitioners to reflect these changes and to test more realistically the applicant's ability to solve the nursing care problems typically found in nursing practice.

Under the new system, aspiring candidates who fail any part of the comprehensive examination will have to rewrite the entire exam. Compared to the soon-to-be-deposed five-part examinations which allow students to rewrite only the subject(s) in which they fail to obtain a passing mark, this undoubtedly imposes a new degree of difficulty on prospective members of the profession. The director of the CNA Testing Service, Eric Parrott, comments: "The 'old' registration examinations were based on a medical rather than a nursing model."<sup>1</sup> That same medical model has been under constant attack by nurse educators and has divided nurses into opposite camps of incompatible loyalty to the old and so called 'new'.

CNA contends that the new comprehensive examination will test the candidate's cognitive abilities by requiring the writer to demonstrate the integration of the elements of knowledge basic to a discipline in solving problems presented in a series of situations.<sup>2</sup> Many educators will confirm, with some degree of justification, that up to now there have been no examinations which really separate the competent from the incompetent with any degree of accuracy. Also, in assessing through examinations whether or not a person will make a good nurse we are looking at probabilities, not certainties.

What magic spell has the word 'integration' cast over the nursing profession in Canada that would influence it to invest 10 years and untold sums of money on the development of an examination to accommodate the concept of integration? Within the framework of nursing curriculum, the word 'integration' implies blending the nursing content in such a way that the parts of specialties are no longer distinguishable. This involves concentrating on the generalizations relating to nursing rather than specifics.<sup>3</sup> It is obvious that the 'old' examination for registration does not meet this criterion. Is this a handicap of such magnitude that it has to be eradicated as a pest? Or is it a reality compatible with today's practice of nursing?

We keep hearing that emphasis should be placed on the promotion of health rather than on the treatment of disease. Theoretically, this emphasis is sound but in actual practice it is incompatible with today's practice mode. Call it shortsighted if you like but if you ponder for a moment, you soon realize that it is the treatment of disease which, much to our chagrin, is still keeping the majority of our colleagues employed and thus, indirectly, keeping our professional hopes and aspirations alive by providing us with time and space to manoeuvre.

I wonder how many nurses today remember the introduction of the two-year diploma program in schools of nursing in the late sixties? During that trying time, many nurses were accused of being shortsighted and labelled obstacles in the path of progress and change. Now, a few years later, we have commission after commission being set up to assess the merit (or demerit as the case may be) of the two-year program.

Is it any wonder that practicing nurses look with suspicion upon nurse educators? Is it any wonder that they tend to think of them as ivory tower architects who have been known to be wrong in their design but who refuse to admit their mistakes? Let us be realistic. The wards and units of the hospitals we work in today are still designated as medical, surgical, obstetrical and gynecological, pediatric and psychiatric. Should nurse educators be pushing for integrated wards or units to accommodate the products of our integrated exam system? Nursing service or administration does not recruit an integrated nurse to fill a specific vacancy. Nor do educational institutions. Also, where are we going to find an integrated textbook to teach our integrated nursing students? Why do educators acknowledge the presence of the medical model and yet defy its existence? The only thing that appears to be 'integrated' is the CNA examination.



While the CNA Testing Service is forging full speed ahead on the integration bandwagon, the trend in the United States, where the concept of integration was conceived and born and where we got our ideas from in the first place, is reversing itself. A few schools of nursing have already jumped the integration track and are headed off in other directions. As more faculties feel comfortable and secure in openly conceding the limitations of the integration syndrome, new avenues will be explored and new compromises made. The school of nursing at the University of Kansas, for one, has opted for compromise between integrated and logistic tactics, which is a disease-centered or body systems approach to teaching. Had nurse educators been realistic earlier, perhaps we would not have been swayed by the magic word, "integration".<sup>5</sup>

I am convinced that if we look closely, we will find that the wheel has turned full circle and if, in turning with it, we have learned anything at all, we must change our behavior to accommodate this newly acquired knowledge. It is about time that as educators we put our act together so that we can command the respect of practicing nurses. ♣

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**About the author:** Mohamed H. Rajabally is probably best known to CNJ readers as the author of "Nursing Education: Another Tower of Babel?" which appeared in the September 1977 issue of this journal. He is a lecturer in the Faculty of Nursing at Okanagan College in Kelowna, B.C. and is also a PhD student in the College of Education at Washington State University, Pullman, Wa.



## CNA's Director of Testing Service Responds:

I have difficulty deciding what message the author is trying to convey about integration, examinations and nursing education. Is he recommending that examinations should be abolished, or questioning whether we have yet found the right techniques to develop examinations that will separate competent from incompetent nurses with accuracy? Does he believe the registration examination should measure specialities, or that integrating content only allows the testing of generalizations? Is it his contention that nursing cannot support the "promotion of health" and "treatment of disease" at the same time, and because so much of today's health care is related to curing disease, that we should not strive for change in trying to promote healthier lifestyles? Does he believe that two-year diploma programs are educationally unsound and that somehow this is related to the integration of nursing content, or to the fact that nurse educators implemented such programs against the better judgment of experienced practitioners?

While I can understand that the expectations nurse educators and nurse practitioners have of new graduates may not be congruent (though I hope their broad goals or objectives are), to suggest that educators should "push for integrated wards or units to accommodate ... (the) products of integration" leaves me puzzled. I hope that a nurse who has been educated in an "integrated" program would make positive transfers of learning and perform competently in a variety of settings (medical, obstetric, and so on), once any additional preparation needed to work in a particular setting has been acquired. Although it might be useful for hospitals and educational programs to have the same organizational structure (either integrated or divided into clinical areas), I don't see that it is essential. It seems to me that the aim of many integrated programs to place nursing in a problem-solving context so that knowledge and nursing care are not fragmented is most appropriate, and just as relevant in practice on a psychiatric unit as on a surgical unit.

As for the statement that "we get our ideas in the first place" from the United States, I have a lot of affection and respect for my American friends and colleagues, but I don't think a Canadian idea has eighty-five cents worth of merit while an American idea is worth one dollar. Nor do I think that Canadian nurses are unable to generate new approaches to nursing education and practice. I hope that the American schools which have "jumped off the integration track" are not like the horseman who rode off in all directions at once. I suspect that no school of nursing, American or Canadian, has discovered the "ideal" curriculum. Therefore, to find that an integrated program has some limitations is not surprising. My hope is that nursing educators will design curricula to reflect their own individual beliefs and needs ... not jump on the "integration bandwagon" just because the CNA Testing Service is integrating examination content, or because it seems to be the popular thing to do. A variety of educational approaches might be more interesting than trying to fit all programs into the same mold. Whatever approach a school of nursing uses, I earnestly hope the nurses graduating from it are "integrated". If not, who will put Humpty Dumpty together again?

I predict that well-prepared candidates, whether from an integrated program or not, will be able to pass the comprehensive examination. The key concept is competency in nursing — not integration.

**Eric G. Parrott**  
Director of Testing Service



# Contract Learning:

## The Experience of Two Nursing Schools

*Jeannette Bouchard, Marilyn Steels*

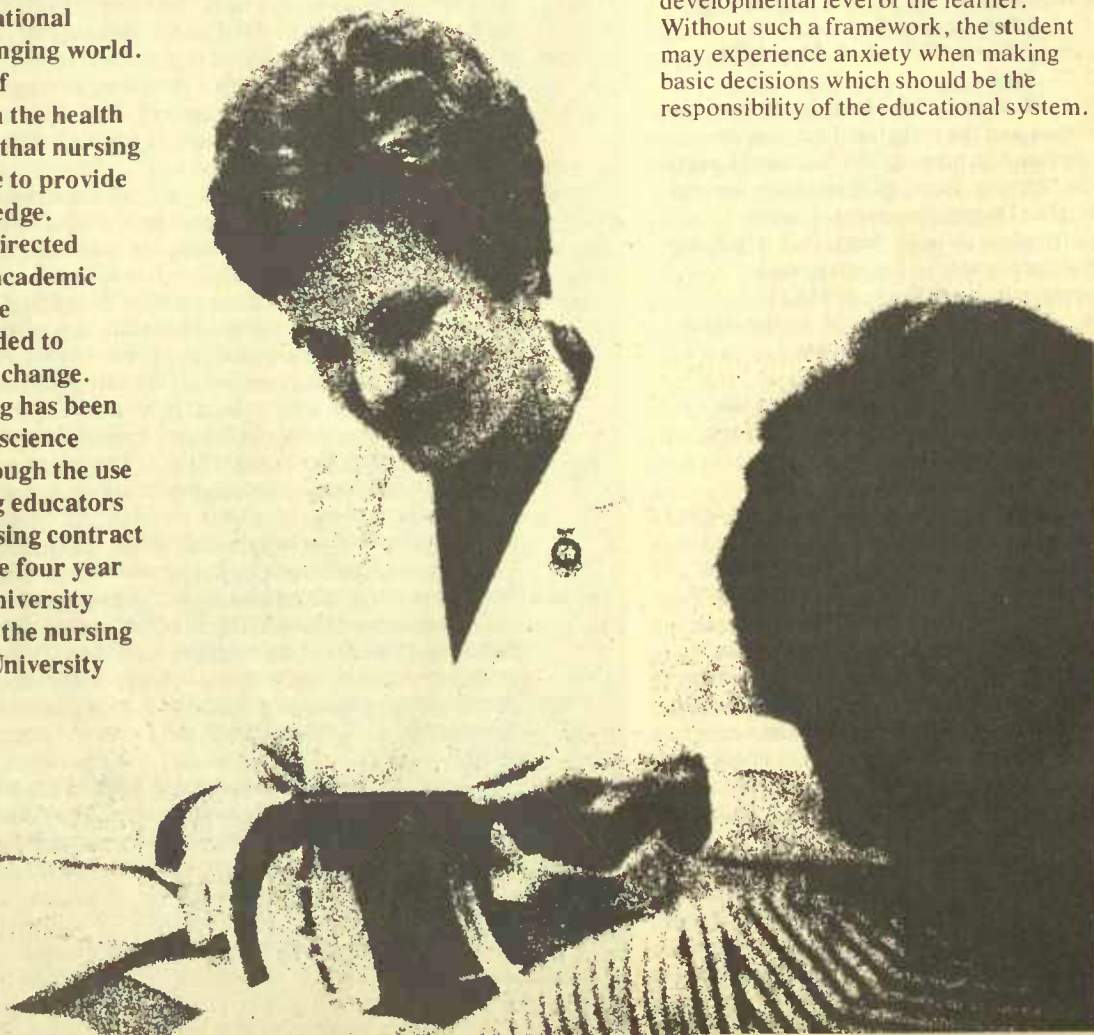
**The nurse as a change agent! Coping with change! Can nursing educators afford to take the risks involved in inviting students to participate in the selection of their own learning experiences?**

Preparation of the student for on-going learning is a major responsibility of the educational system in our rapidly changing world. Given the short half-life of professional knowledge in the health field, it seems imperative that nursing educators no longer strive to provide a finite package of knowledge. Opportunities to be self-directed within the security of an academic milieu should facilitate the development of skills needed to assume responsibility for change.

Self-directed learning has been promoted in two nursing science programs in Ontario through the use of contracts. Two nursing educators share their experiences using contract learning in year two of the four year program at McMaster University (1976-7) and year four of the nursing program at Laurentian University (1977-8).

"A learning contract is a document drawn up by a student and his instructor or advisor which specifies what the student will learn, how this will be accomplished and within what period of time, and what the criteria for evaluation will be."<sup>1</sup> Contract learning, like independent study, places more

responsibility on the learner for planning his own work and pursuing his own objectives, while the instructor remains responsible for developing a broad framework of course objectives and expectations within which each student develops his specific contract. The detail and scope of this necessary framework varies according to the experience and developmental level of the learner. Without such a framework, the student may experience anxiety when making basic decisions which should be the responsibility of the educational system.





A learning contract has many positive attributes; it

- supports the learner's self-concept as an autonomous adult with a background of personal experience and expectations for the future which help him identify personal learning needs.
- permits the identification and confrontation of real and relevant problems rather than confinement within a prescribed subject-centered learning mode.
- promotes a sense of personal responsibility for learning.
- permits more relevant and meaningful learning experiences.
- allows the instructor, being freed from the constant strain of content transmission, to focus on the individual student and his progress.
- promotes competition with self to meet self-formulated standards rather than competing with peers.
- provides a vehicle for communication between student and teacher.
- assures on-going personalized feedback between student and teacher.
- provides a clear record of the student's personal learning process.
- promotes expression of creativity by inviting and encouraging students to take risks in designing their learning experience within the boundaries of the course objectives.

However, effective contracting requires several essential basic conditions, such as compatibility with the school's philosophy; commitment and security on the part of the instructors; a clear set of general course objectives; an acceptable and well-delineated set of requirements and expectations and an explicit procedure for contract development; intensive facilitative interaction between student and instructor; formative rather than punitive evaluations; peer support within both student and teacher groups; and effective public relations with resource individuals and agencies.

#### **The authors' experiences**

The contract learning process was applied in two nursing courses which combined theory and practice. The year two course focused on human growth and development throughout the lifespan with the students working with well children and families at varying stages in the maternity cycle in one term and with individuals and families experiencing situational crises related to surgery in the second. Core plans brought students from both rotations together to discuss broad concepts relevant to all areas of nursing. The year four course, taken in one term, focused on the analysis of individual practice by selecting and

exploring in depth one theory of nursing and applying it clinically with several patients and families. A research study, used as a theoretical base, was carried out and small group seminars considered the application of the theory clinically and implications of the research.

Initially, terminal objectives were presented and discussed. In a group setting, the students were asked to identify factors which helped and hindered their learning; using this input, beliefs about the adult learner and self-directed learning were identified. This paved the way for the introduction of contract learning. In both instances, a class was devoted to the purpose of this tool and details of its implementation. Handouts were given explaining expectations and clarifying the steps of contract development. These guidelines included examples of appropriate learning activities, suggestions for suitable types of evidence of learning in each domain and suggestions for the development of criteria and means for validating this evidence. As well, options were described for students who failed to meet their contracts.

Although the process remained similar in both courses, it was in the application of the specific expectations that differences occurred. The "givens" fell into five categories: final dates for contract negotiation and submission of evidence, content, requirements for specific types of evidence, a requirement for a grade "C" contract, and provision for work in groups. In both groups, contracts were to be finalized three weeks before the end of the term with a final date for submission of evidence also specified to allow faculty time to complete an evaluation. The content givens guided the students to develop objectives and select learning experiences relevant to the course.

In year two, we intended that the contract:

- focus on health, not pathology
- relate to an age group within the scope of the student's current clinical rotation
- show the application of one of the core concepts under study in class that term
- and show the relationship of the planned learning activities to the conceptual framework of the course.

In year four, the contract was to:

- develop a personal framework of nursing practice
- reflect an analytical approach to the process of nursing care
- and utilize a selected concept in the scientific investigation of a nursing problem.

In year two, a formal essay was required as partial evidence of contract fulfillment and in year four, a formal research paper was to be completed.

The grade C contract requirement was included to ensure that students who overextended themselves would have a more easily attainable contract to fall back on. However, a grade A or B contract could be negotiated based on changes in or additions to objectives, learning activities, as well as evidence and/or criteria for evaluation.

Criteria for group projects were established to assure each group member of a personal evaluation. Each student was expected to develop his own contract and was held accountable for producing evidence congruent with his objectives and negotiated grade.

#### **Faculty strategies to facilitate the process of contracting**

Certain provisions were made in advance to assure that the experience of contracting proceeded as smoothly as possible for both students and faculty. Regular appointment schedules were established with a specific weekly time assigned for second year students to meet with their instructor, while fourth year students were expected to set up their own appointments as they deemed necessary. An average of 20 to 30 minutes were spent weekly with each student discussing matters related to the contract; this time investment was necessary for both groups.

Provisions were made for mediation of contract disputes in both cases. In year two, time was spent in team meetings almost every week discussing contracts, with student representatives involved in much of the discussion. In addition, a special time was set aside just before the date for contract finalization to resolve any impasses. The fourth year students were informed that if an impasse in contracting occurred, another fourth year faculty member would be invited to serve as mediator.

Class size and attendant faculty numbers did not constitute a problem at Laurentian University. At McMaster University, however, a major concern for students and faculty alike was the issue of achieving fairness when six faculty were involved in setting 70 or more learning contracts. When the diversity of projects is such that equivalence of work is difficult to assess, students become competitive with each other and faculty are forced into the difficult task of trying to be consistent not only with each other but with themselves. Time spent in team meetings, as well as one to one discussions amongst faculty, were used to ensure consistency.



To avoid frustrating and non-productive delays in the student learning process, students were encouraged to begin to pursue their learning activities before their contracts were finalized. Their learning experiences during this period of contract evolution lessened their anxieties and helped them clarify their specific areas of interest and learning needs.

Although anything that was legal, ethical and feasible within the contract requirements was encouraged, some guidance was provided to year two students in relation to appropriate topics and learning resources. This guidance was provided through sets of thought-provoking questions, lists of faculty and community expertise, and packages containing written resources in

a variety of areas. Students were encouraged to add to these packages and to use a special bulletin board that was set up for conveying information relating to various learning experiences. In both situations, letters of introduction were prepared on school of nursing letterhead for students wishing to establish contact with persons not previously solicited by the school. For the fourth year students, resources were provided but not categorized under specific topics per se;

<b>LEARNING CONTRACT FOR COURSE:</b> NSG 2004		<b>Student:</b> Jane Myles <b>Date Evidence Will Be Submitted:</b> April 16, 1979	<b>Instructor:</b> Marilyn Steels
Learning Objectives (include relationship to course expectations)	Learning Resources and Strategies	Evidence of Accomplishment of Objectives	Criteria and Means for Validating Evidence
<b>FOR C GRADE</b> 1. To discover what community resources are available for colostomy patients.	Interview Board of Directors of Ostomy Association. Interview ostomy nurse.	Bib. card: listing and describing community resources available to ostomy patients.	Name of resource person. Description of community service, location, function for ostomy patients, group activities.
2. To identify resource personnel, their contributions to patient care. To share this knowledge with peers and other health team members.	Arrange with ostomy nurse to come and speak to a group of nursing students and other health team members.	Presentation by ostomy nurse takes place on March 25. Evaluate whether knowledge has been passed on to peers through a questionnaire given after the presentation. Summarize in chart form the response to the questionnaire.	Tutorial leader comes to presentation. Questionnaire: general questions concerning knowledge gained from the presentation. Chart representation of response.
3. To learn to conduct an information gathering interview with resource personnel.	Interview an ostomy patient concerning any physical/psychological adaption problems encountered after the operation.	Written evaluation of interviewing skills. Analyze adaptive process. Consider the effects of the colostomy on the developmental tasks of the adult interviewed.	Criteria for good interviewing skills. Introduction of self and topic of study. Open-ended questions. Summarized interview and concluded interaction. Evaluation of interview. Stages of adaption patient went through; difficulties; present stages.
<b>FOR B GRADE</b> 1. Same as 3. (above)	Same as above.	Same as above.	As above item plus refrain from giving advice/being judgmental. Identifying and validating verbal and nonverbal cues. Utilizing this data, maintain the interview. Evaluation of interview. Stages of adaption.
2. To plan and implement a teaching approach for peers so that they gain a basic understanding of the psychological stages of adaption which a colostomy patient progresses through.	Poster	Discussion following presentation of poster, focusing on anecdotes in which there were manifestations of the psychological adaption stages. Include the effects of the colostomy on the growth and development of the adult. Presentation on Tuesday, April 5.	Presence of tutorial leader to make sure psychological adaption and growth and development are included in presentation. Clarify at presentation. Helping group to problem solve through anecdotes. Response of group to discussion of anecdotes. Ability of group to identify stages of adaption as presented in anecdotes: will either teach or help in problem solving.
<b>A. Contract successfully negotiated for a B grade.</b>	Mar.25, 1979	<b>Student:</b> Jane Myles <b>Instructor:</b> Marilyn Steels	
<b>B. Contract successfully met for a B grade.</b>	April 16, 1979.	<b>Student:</b> Jane Myles <b>Instructor:</b> Marilyn Steels	



it was left to the student's initiative to seek out pertinent resources as well as letters of introduction.

Guidelines were provided for students in both settings in relation to expectations for the fulfillment of grade A, B and C contracts. It was hoped that students would grasp the idea that quality of work was at least as important as quantity. Examples were given showing how different words and phrases used to describe learner behaviors can reflect the quality and complexity of the learning process. Also suggestions were given describing types of evaluation tools available for specific types of evidence. The use of external appraisers for evaluation of evidence was encouraged. By including the name of the proposed evaluator and his/her qualifications in the contract, the idea was reinforced that the teacher was not necessarily the best qualified person to evaluate the student in all areas, but remained the person responsible for the overall evaluation of student performance.

#### **Evaluation of the experience**

The gains from contracting exceeded the investment of time and effort by all parties involved. Released from the restraints of traditional course requirements, students and faculty freely expressed their creativity. Although initially students were hesitant and insecure in making their own decisions about learning, contracting provided an outlet for creative drives. Students who had previously viewed themselves as creative, were almost immediately enthusiastic, while others discovered within themselves their potential for innovation. In this latter group, an almost metamorphic change was noted when self-pacing was allowed. An inevitable effect on faculty was a feeling of excitement and pride. A by-product of the wide range of activities generated by this atmosphere was the increased visibility of both schools within their respective communities.

The time required to work with individual students in contract development, while necessary, proved to be a continuous drain on faculty time and energy. At certain peak periods, such as just before contract signing, this demand became a source of frustration, especially for those faculty with less flexible schedules, with the result that time spent discussing contracts in team meetings frequently took precedence over other pressing business.

In neither case did contract disputes occur in the true labor relations sense.

Because of the large number of students and faculty involved in the McMaster experience, however, some degree of inconsistency was inevitable. Although some students did question the degree of fairness, generally concerns were resolved through discussions in team meetings and consultation with faculty. Informal consultations were more effective than the formal mechanism set up for resolving impasses.

Most students began to implement their learning plan early in the term, and as anticipated, the process of contracting helped them focus their energies as the term progressed. As with all assignments, there were some students who were slow starters, resulting in stress for both students and faculty.

The mechanisms set up to assist students in securing learning resources varied in their effectiveness. In year two, the packages of learning resources proved useful, but the response of students to the suggestion that they add resources to these packages was somewhat disappointing. As few students used the bulletin board to inform others of their intent to contact community resource people, many resource persons were approached several times with similar requests. These situations were not encountered with the fourth year students given the numbers and variety of interests and endeavors involved. The learning resources that were provided, such as various research instruments, bibliographies specific to certain concepts, lists of resource persons and guidelines for the use of local libraries, proved helpful. In both situations, letters of introduction were useful in establishing student credibility.

The guidelines describing expectations for A, B and C grades were essential as this was the first exposure to contracting for both groups. As with any individual learning experience, however, a certain degree of subjectivity was inevitable. This posed a problem, particularly when faculty and students, inexperienced with the contracting process, set evaluation criteria that were so general that the judgment regarding their achievement had to be subjective. Because contracts were finalized three weeks before the end of the term, an unforeseen problem arose. Some students submitted evidence which exceeded specifications of their contract and there was no provision in the process for upgrading their mark. This seemed unjust, particularly in view of the reasons for contracting and the fact that a lower grade could be negotiated if the student failed to meet the stated requirements.

The requirement that each student begin by writing a C contract became a cumbersome and redundant exercise for students who had their sights clearly focused on achieving an A or a B from the outset. Those who saw themselves as C students at the beginning would probably have chosen to begin with a C contract anyway, although they often changed their self-expectations as the term went on.

In both groups, faculty were impressed by the creativity displayed by the students. One form this creativity took was the development of original tools for evaluation. The use of external appraisers for evaluation was more common in year four than year two but in neither case, did students take full advantage of the resources available outside of the school of nursing, probably partially due to a lack of previous exposure of service personnel to this role.

More students seemed to opt for working in groups in year two than in year four, which probably was indicative of the developmental level of the learners and the fact that year four students were in individualized clinical placements according to their personal interests. When students did choose to work in groups, it became difficult in both situations to clearly differentiate the work of one student from the work of the other and frustrations in contract writing and in evaluation of evidence resulted.

#### **Recommendations**

Contract learning has now been implemented in all four years of the nursing science program at McMaster University and its use at Laurentian University is increasing. For those interested in integrating this type of learning experience into their nursing program, these are our recommendations.

1. As creativity is inherent to contracting, provisions for its expression must be provided, as early as possible in the experience. However, guidelines are essential, with the need for detail and specificity varying with the developmental level of the learner.
2. The time commitment necessary in contract learning precludes the use of this strategy by faculty who function in situations demanding a large student-teacher ratio. A maximum ratio of 12 to one is recommended. Provision must also be made for discussion among faculty, with the most effective communication frequently taking place on a one-to-one level.



3. A formal mechanism to deal with contract disputes, although rarely required, will give both students and faculty a sense of security.

4. Initial contracts should be signed within the first six weeks of the term to help the students pace their learning experiences. By incorporating provisions for contract negotiations until the termination of the course, difficulties which arise when evidence submitted does not match the specifications of the contract are eliminated.

5. Several mechanisms to assist students secure learning resources should be provided with a continuing emphasis on the responsibilities of faculty and students to build shared resources. Methods to ensure community resource persons are not overloaded with student requests should be devised.

6. Faculty groups must predetermine common expectations for quantity and quality of work required for the fulfillment of A, B and C contracts. Students should be permitted to negotiate at any contract level, with provisions for up or down grading.

7. As external appraisers are identified they must be oriented to their role in student evaluation through a basic orientation to the philosophy and mechanics of contracting.

8. Resource persons outside of the school system should be given feedback through letters of thanks or copies of student work.

9. Although evaluation of individuals working within a group is difficult, group work should be supported, perhaps by accepting group contracts and giving group grades. This would place the onus on the students to ensure that all members of the group contributed equally; failure to contribute to the full extent, would mean that the individual would not benefit from internalization of the learning experience. The tedious process of settling on grades for contracts left the authors questioning the appropriateness of assigning grades to contracts at all. ♣

#### Reference

\*Donald, J.G. Contracting for learning. *Learning Development*, April, 1976. p.2.

\*Unable to verify in CNA Library



**Jeannette Bouchard**, a graduate of St. Elizabeth School of Nursing, Sudbury, Ontario, received her BScN from the University of Ottawa and her MScN from Boston University School of Nursing. She is currently an assistant professor with Laurentian University School of Nursing, Sudbury, Ontario.



**Marilyn Steels**, BScN, a graduate from McMaster University, received a Canadian Nurses Foundation Fellowship in 1970 to continue her studies for a MSN at Case Western Reserve University, Cleveland, Ohio. While teaching, as assistant professor with the McMaster School of Nursing, she took part in this project on contract learning. Currently, she is senior nurse with the Niagara Branch of the Victorian Order of Nurses.

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The 1980 annual meeting and convention of the Canadian Nurses Association will be held 22-25 June 1980 in the West and Center Blocks, Regency Ballroom, of the Hyatt Regency Hotel, Vancouver, B.C.

The opening ceremony will be held Sunday evening, 22 June 1980, at 20:00, followed by a reception for members and students. Sessions (business and program) will begin at 09:00, Monday, 23 June 1980, continuing daily and concluding Wednesday afternoon, 25 June 1980, with the President's Reception.

Students enrolled in schools of nursing in Canada are invited to register to observe the proceedings of this Annual Meeting and to participate in the program and social events.





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# audiovisual

## ■ Burns

Prints of the highly regarded CBC film "The Other Child" are now available for borrowing or purchase from offices of the National Film Board across Canada. The 16mm color film deals with the burn unit at the Izaak Walton Killam Hospital in Halifax, N.S. and follows the story of several burned children from admission to surgery and discharge. This film, which has affected everyone who has seen it, is not listed in the regular NFB catalogue; for information contact the NFB office nearest you.

## ■ Resuscitation



### CPR: to save a life

Each year in Canada, almost a million people suffer heart attacks. And in thousands of accidents involving electrical shock, drowning and suffocation, people stop breathing. Cardiac arrest follows the cessation of breathing in a matter of minutes. Many people can be saved by effective cardiopulmonary resuscitation.

In this film, simulated rescue scenes demonstrate basic emergency techniques to be used in the event of cardiac arrest. Each step of the procedure is simply and vividly demonstrated by paramedics and reinforced with illustrations. Adult and pediatric resuscitation included. For information write: Visual Education Centre, 75 Horner Avenue, Unit One, Toronto, Ontario, M8Z 4X5.

## ■ Lifestyles

A large number of medical visits are hypochondriacal in nature. Hypochondriacs are people who will not get well. They have a need to hold onto their symptoms. Doctors and nurses have a need to cure. What develops is a "tug of war"...

The British Medical Association's Gold Award for 1978 has been awarded to "Hypochondriacs and Health Care: A Tug of War". This film is about health care professionals treating patients who have acquired a lifestyle of sickness. It was produced by Workshop Films in cooperation with Dr. Robert R. Rynearson, Chairman of the Department of Psychiatry, Scott and White Hospital, Temple, Texas. An excellent audiovisual aid for all health care professionals.

A 38 minute color 16 mm film or videotape, 1978. Rental: \$40. Sale: \$400 (16 mm), \$350 (video). For further information write Workshop Films, 4 Longfellow Road, Cambridge, MA 02138.

## ■ Choking: to save a life

A film that clearly explains choking rescue techniques to apply to others and to oneself. Trained paramedics demonstrate the back blow, the abdominal thrust and the finger probe. The film also presents ways to avoid choking situations.

For information write: Visual Education Centre, 75 Horner Avenue, Unit One, Toronto, Ontario, M8Z 4X5.

## ■ Autism Minority of one

A film that takes a look at behavioral modification techniques that aim at diverting today's autistic children away from mental institutions and into normal adulthood. For information write: Visual Education Centre, 75 Horner Avenue, Unit One, Toronto, Ontario, M8Z 4X5.

## ■ Childbirth Pregnancy: Two people

A 16 mm color film, 35 minutes in length. A visual record of the pregnancy of J. J. and Richard Clarke. A documentary record of conversations, visits with friends and families, and of the changing feelings of the couple towards each other and the growing baby. The film approaches the Clarkes, the institutions and the people the pregnancy put them in contact with, in an objective way. For information contact: Richard and J. J. Clarke, Change Productions, 18 Ahrens Street West, Kitchener, Ontario, N2H 4B7.

## ■ Childbirth A Labor of Love

A sensitive motion picture dealing with family-centered childbirth and focusing on the impact of pregnancy on an entire family. The film covers expectant parent classes, discussions about pregnancy, birth and post-natal situations with parents to be, the obstetrician, a psychiatrist and a registered nurse childbirth educator, prenatal exercises, animation that demonstrates the normal mechanisms of labor and delivery, father participation in the labor and delivery rooms and more. A 31-minute color sound film.

For further information write: Meducation Inc., 683 Beacon Street, Newton Centre, Massachusetts, 02159.

## ■ Patient education

A new system of patient education is being developed by Medifacts and the College of Family Physicians of Canada, based on the patient's use of audio cassettes and illustrated brochures as learning aids.

This system involves the patient, and often members of his family as well, listening to a cassette dealing with his medical problem.

Subsequently the patient is able to discuss his problem more intelligently with his physician, with greater understanding of the need for patient compliance.

Among the cassettes produced so far are these titles which have a direct application to patients or their family:

1. Growing Up (Adolescence) 46 minutes \$6.95
2. Birth Control (Contraception) 41 minutes \$6.95
3. Drinking and Drugs 37 minutes \$6.95
4. Talking about Sex 89 minutes \$9.95

Each cassette presents information in lay language in the form of dialogue, narrative and dramatized vignettes which often enable the patient to see himself as others see him.

Members interested in further information on these patient cassettes should write to Medifacts Ltd., 43 Eccles Street, Ottawa, Ont., K1R 6S3.

## ■ Continuing education

**The Renal Series**, a functional review for nurses, is now being offered by the University of Kansas Division of Continuing Nursing Education. The sequence of nine modules and accompanying slides is designed to increase the nurse's understanding of renal function and to apply this understanding to the care of patients with kidney impairments. It can be used in independent study, discussion groups, tutorials, or traditional classrooms. For further information write: Independent Study, Continuing Education, University of Kansas, Lawrence, Kansas 66045.



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# research

## • Patient classification

**A Research Report on the Development and Validation of the PCTC System.** Edmonton, Alta., 1979 by K.S. Bay et al., University of Alberta.

A system of patient classification by types of care (the PCTC system) was developed and validated to improve decisions for longterm care patients and to provide information required for planning and resource allocation.

In order to evaluate the PCTC system as a feasible mechanism for making rational placement decisions, it is proposed that a centralized placement service unit (PSU) be established for a suitable region of Alberta and a demonstration project be carried out. An overall summary of the project, findings and conclusions and recommendations for policy consideration, PSU demonstration project and research in general are provided.

## • Single pregnancy

**Punishing the Pregnant Innocents. Single Pregnancy in St. John's, Newfoundland.** St. John's, Nfld. 1978. Thesis (M.S.), Memorial University of Newfoundland by Laura Hope Tounishey.

The primary objectives of this study are to determine from data obtained from 40 single pregnant girls in the city of St. John's a) to what extent social and emotional factors inhibit a healthy pregnancy outcome; and b) whether the established and generally accepted social norms for sex-related behavior are relevant to the attitudes and behavior of young people living in St. John's.

The primary concerns of those interviewed were closely related to their perceptions of anticipated responses from parents, sexual partners and social groups etc. Data analysis also served to identify significant emotional milestones during an illegitimate pregnancy.

A discussion of the role and responsibility of a society to prepare its youth for future sex relationships and parenthood revealed that there were serious discrepancies in attitudes and services within the existing socialization process.

The extent to which specific punishments are imposed upon pregnant, single girls are described in this study.

Recommendations for changes in social attitudes and approaches to the problems associated with illegitimate pregnancies in St. John's are included.

## • Gerontology

**Health-Related Problems of Elderly People Attending Senior Citizen Clubs/Centers.** Mississauga, Ont. 1979, by Isabel Milton.

The purpose of this comparative study was to investigate the nature, frequency and severity of the health-related problems of elderly people attending senior citizen clubs/centers.

Data was collected in three senior citizen clubs/centers; 24 suburban and 36 rural subjects completed a questionnaire with the investigator present and 25 of the 32 urban subjects completed the questionnaire as a structured interview guide as they were unable to read English.

Across settings, more than one-third reported health problems related to vision, medication therapy, indigestion, appropriate diet, appetite and blood pressure and one-quarter reported health problems related to self-esteem and life satisfaction.

Health professionals were used to cope with health-related problems to a much greater extent than the social network, with the physician being utilized the most frequently. The least utilization of the nurse was reported in the rural setting.

This study emphasizes the increased need of nursing services to the "well-elderly" in geographically convenient and established settings. ♡



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# books

**Special techniques in assertiveness training for women in the health professions** by Melodie Chenevert. St. Louis, Mosby, 1978.  
*Approximate price: \$9.75*

The author, Melodie Chenevert, B.A., M.S., formerly an instructor at the University of Wisconsin, School of Nursing, indicates in the preface that within the health care system women account for more than eighty percent of all health care workers. She suggests that women have been the silent majority, rarely voicing opinions concerning patient care. Women have traditionally been nonassertive and it is now time to prepare to challenge the authorities in health care to provide a responsive and responsible system.

The chapters of the book have unique titles (e.g., Of Chickens and eagles, Chicks and roosters, How to tell a turkey to stuff it!), and excellent photographs complement the content. An annotated bibliography provides additional resources for the reader.

This book provides a perspective on the reasons women tend to be nonassertive in the health care field, and gives numerous examples of situations with which every nurse can identify.

Throughout the book positive examples and strategies are provided to assist in developing assertiveness. Overall, the book provides light interesting reading for all women.

But, I cannot recommend the book for educational purposes because while it focuses on women's nonassertiveness, it does not in turn adequately delineate the activities necessary to change this situation.

*Reviewed by Janet L. Moore, Associate professor, Faculty of Nursing, University of Calgary, Calgary, Alberta.*

**Guide to Nursing Management of Psychiatric Patients** by S. Dreyer, D. Bailey and W. Doucet. 2nd ed. Toronto, C.V. Mosby Co., 1979.  
*Approximate price: \$12.00.*

This book is intended primarily for undergraduate psychiatric nursing students and to be used as a teaching tool for nursing instructors. It utilizes a workbook format based on clinical cases to facilitate the transfer of applied theoretical material from an intellectual exercise to the actual clinical situation.

The second edition has been updated in view of the trend to treat patients in their own communities

instead of in centralized treatment centers, the greater awareness of potential danger in treating individuals simply as diagnostic entities, tightened criteria for involuntary admissions and a greater awareness of the rights of the mentally ill.

The conceptual framework utilized for presenting the major psychiatric disorders is anxiety and defense mechanisms, which is sometimes

inadequate in teaching schizophrenia and affective disorders.

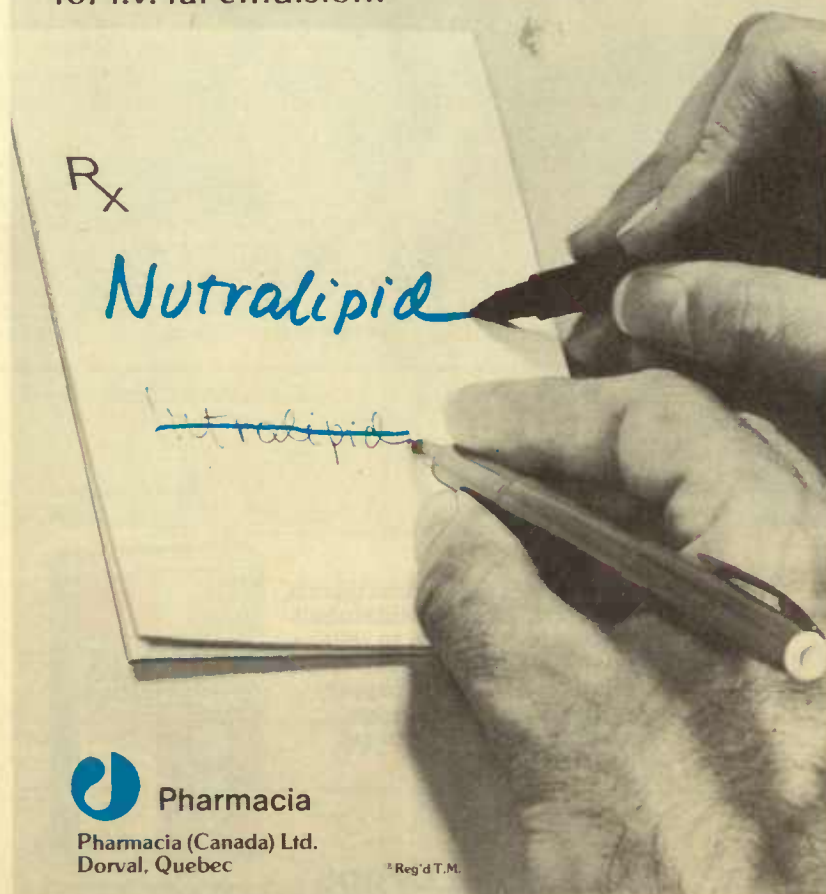
This guide is recommended for students preparing for their exams but not alone as a reference as it requires prior reading and/or supplemental texts.

*Reviewed by Marilyn Robbins, educational consultant, Hamilton Psychiatric Hospital, Hamilton, Ontario.*

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Teaching clinical nursing ed. by S.M. Hinchliff, New York, Churchill-Livingstone, 1979. Approximate price: \$15.00

This British paperback attempts to give practical help to the nurse teacher in both the clinical area and community. Basic information and guidelines on many aspects of teaching are discussed by various contributors, making the book useful for a new teacher.

Hinchliff initially discusses "the process of clinical nursing" in which

excellent guidelines are given for obtaining a very thorough nursing assessment and a clear, comprehensive outline of all phases of the nursing process.

Despite differences in nursing education between Britain and Canada, many problems encountered on the ward are of a similar nature and useful information is given for planning a teaching program on the unit.

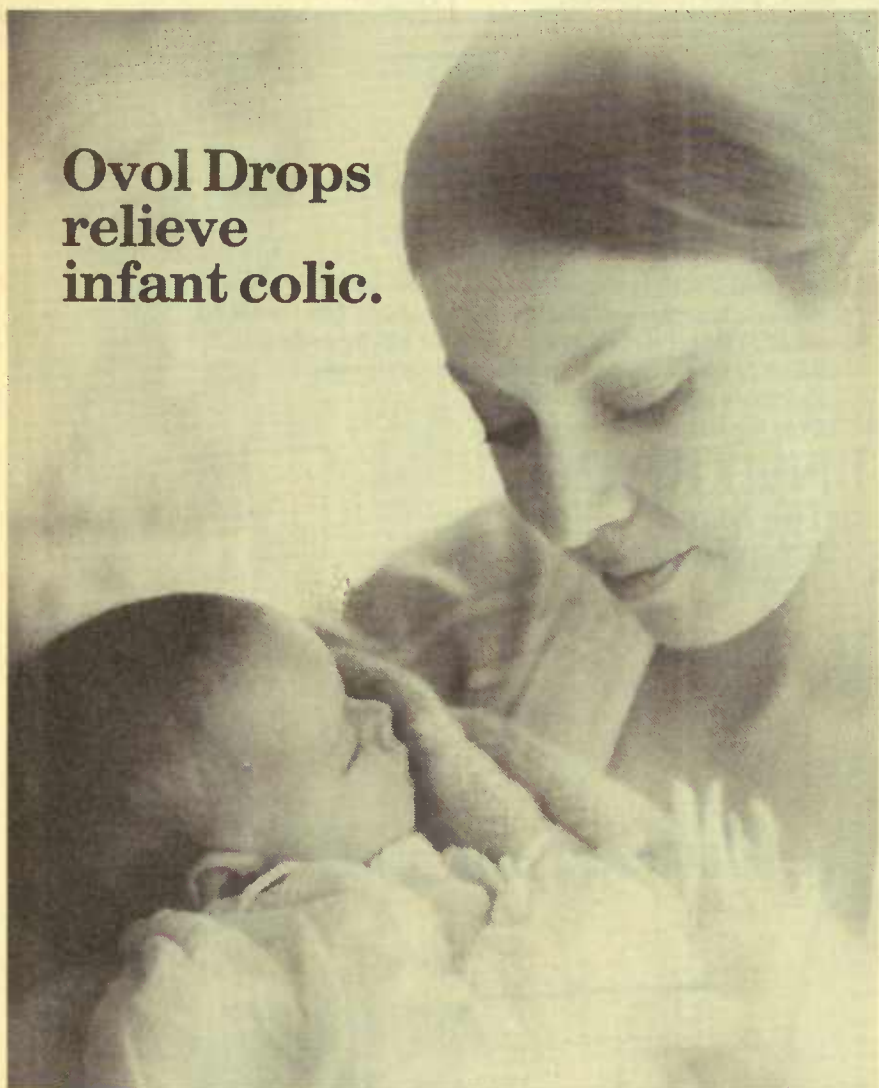
One main theme throughout is the emphasis on the need for good communication between the ward staff

and the students and teacher. Another is that of student anxiety in the clinical setting which can adversely affect student growth, independence and performance and which all too often may be overlooked by an experienced ward staff or teacher.

There is some repetition of educational theories and approaches to learning which tends to lessen the intent of the reader; however, there are many good ideas discussed in the chapter on "Teaching resources", and guidelines as to using the many resources available today. A chapter on "Teaching psychiatric nursing" is applicable to any clinical situation and not specific to psychiatry; the use of role play as a teaching device, however is discussed on a most superficial level. Guidelines which would have been useful for teachers are missing which is unfortunate since this method can offer so much toward the development of empathy, self-awareness and attitude-change. Few books are written on teaching clinical nursing and this is a useful library addition because of the many practical guidelines it offers for sound planning.

*Reviewed by Kathleen Young, R.N., B.Ed., Teaching master, Seneca College School of Nursing, Willowdale, Ontario.*

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#### CONTRAINDICATIONS

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#### PRECAUTIONS

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#### ADVERSE REACTIONS

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#### DOSAGE AND ADMINISTRATION

OVOL 80 mg TABLETS

Simethicone 80 mg

OVOL 40 mg TABLETS

Simethicone 40 mg

Adults: One chewable tablet between meals as required.

#### OVOL DROPS

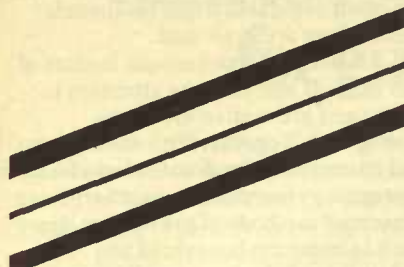
Simethicone (in a peppermint flavoured base) 40 mg/ml

Infants: One-quarter to one-half ml as required. May be added to formula or given directly from dropper.

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By **Marshall H. Klaus, MD**, Prof. of Pediatrics; and **Avroy A. Fanaroff, MB, (RAND)**, MRCPE, Assoc. Prof. of Pediatrics, both of Case Western Reserve Univ. School of Medicine, Cleveland, OH. 437 pp. Illustd. \$23.40. July 1979. Order #5478-9.

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By **Nancy Ann Corbett, RN, EdM**, Assoc. Prof., College of Allied Health Sciences, Thomas Jefferson Univ., Phila., PA; and **Phyllis Beveridge, RN, EdM**, Lecturer, College of Health Sciences, Univ. of Bridgeport, CT. 332 pp. Soft cover. \$11.95. January 1980. Order #2722-6.

## Keane & Fletcher **DRUGS AND SOLUTIONS: A PROGRAMED INTRODUCTION**

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## Drain & Shipley **THE RECOVERY ROOM**

Two leading experts provide clear, accurate coverage of the recovery room in this exciting book. Topics include the physiology of anesthesia, the effects of various anesthetic agents, specific care after all types of operations, and factors that affect recovery from anesthesia in particular patients.

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## Lee **CONCEPTS IN BASIC NURSING: A MODULAR APPROACH**

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**Documenting patient care responsibly** Skillbook Series, Nursing '78 Books, Horsham, Pennsylvania, Intermed Communications, Inc., 1978, 191 pages. Approximate price \$8.95, hardcover.

**Documenting patient care responsibly** is one volume of the Nursing Skillbook Series intended for education in nursing in order to provide quality patient care. There are nine authors, and more than twenty-five contributors, but the presentation style remains consistent and well integrated throughout. Like the previous Nursing Skillbooks, this book is rich in the use of visual aides, caricatures, anecdotes, charts, graphs and summaries. The text is easy to read, easy to follow and enjoyable to learn from.

Self assessment of learning is provided in the form of Skillchecks which are multiple choice questions at the conclusion of each section. Answering the Skillchecks requires synthesis and application of information in simulated situations. Answers and the appropriate rationale are provided at the end of the text.

Not a book intended to teach or improve skills in traditional source-oriented charting, it explains and clearly outlines a viable alternative which is gaining increasingly widespread acceptance — the SOAPIER method: S - subjective data (what the patient says he feels), O - objective data (what you observe and inspect), A - assessment (ongoing), P - plan, I - implementation of the plan, E - evaluation of the implemented plan and R - revision. Problem oriented medical records (POMR) first introduced by Dr. Lawrence L. Weed in 1958, is the basic theory upon which the text is based.

The book begins with an overview of the nursing process; this is a valuable and concise review for students and active graduates or a sound introduction for nurses returning to practice. The authors emphasize throughout that charting according to the nursing process is essential in order to provide quality patient care.

The text proceeds systematically and progressively through the phases of data collection, assessment, identifying needs, planning care, recording progress and evaluating the plan. Legal considerations are also incorporated within each section.

The bias of this text is clearly against source-oriented charting and toward POMR. It would appear that the use of POMR is becoming increasingly popular and it is therefore imperative for nurses to update their skills independently or as part of a continuing

education program. **Documenting patient care responsibly** is suitable for use in either way and would also be a valuable reference source for those individuals or institutions interested in implementing the POMR system of documentation.

*Reviewed by Susan J. Carmichael, Instructor, Faculty of Nursing, St. Clair College of Applied Arts and Technology, Windsor, Ontario*

**Manual of Critical Care** by Linda Feiwell Abels, R.N., M.N. St. Louis, Mosby, 1979.

This book is geared to the critical care practitioner; it may serve as a technical reference for those involved in a variety of critical care settings or as a resource for nurses being introduced to intensive care nursing, and for instructors in the special care areas.

The format is well organized and comprehensive. Various aspects of critical care are discussed, from life maintenance to disaster planning. There is, however, limited content on coronary care. Since this is purely a technical text, it lacks an individualized patient care approach and does not provide description and specific management of major disease processes encountered in critical care areas.

Of special interest is the chapter on physical assessment which is very informative and systematically approached and there is a thorough description of laboratory tests commonly used in intensive care areas for quick reference.

The author also presents an in-depth discussion of basic and complex nursing procedures and equipment which would be useful, not only in critical care areas, but also in a general ward setting. Included are numerous illustrations and pictures.

Each chapter has a comprehensive bibliography and the book ends with appendices on cardiac rhythms with indications for treatment, as well as a summary of various drugs.

Overall, this book is worthwhile reading for anyone providing care to the critically ill patient.

*Reviewed by Emma C. Glua, R.N., Nurse Clinician, Coronary Care Unit, Vancouver General Hospital.*

**Emergency first aid, safety oriented** [Ottawa] St. John Ambulance, c1977.

This new St. John Ambulance First Aid Manual is dedicated, as its title would indicate, to the teaching of emergency first aid and personal safety precautions. As expressed in Dr. Salter's foreward, the "ultimate goal of St. John

in Canada is to provide at least the basic concepts of First Aid and Safety to every trainable citizen in the country". To achieve this purpose, the practice of first aid is presented within the framework of loss control; in its effort to prevent loss of life, of health, of productive time and of money to the individual, to the community, and to the country at large. The manual subscribes to the belief that accidents leading to the need for first aid are often avoidable when reasonable precautions are exercised.

Indeed, the most unique feature of this first aid manual is its attention to safety and preventive measures throughout. Together with descriptions and illustrations for practical modes of emergency treatment, the authors have presented methods of preventing injury such as common household and industrial accidents, as well as our classic environmental injuries. For example, the chapter which includes cold exposure comes complete with temperature chart, index of wind chill factors, and advice on suitable clothing.

The information presented is readily understandable, and would well serve as a handy reference manual for professionals and non-professionals alike. I was pleased to see the inclusion of the abdominal and chest thrust procedures for victims of choking, and would recommend that anyone likely to make use of cardiopulmonary resuscitation should explore the St. John Ambulance special course or request additional instructional materials as explained on page forty of the manual.

Pertaining to safety in another dimension, the authors do not fail to point out situations where the first aider is limited in his intervention skill, and thus where professional help must be sought immediately.

Several strong features of this publication are the modification of various emergency procedures when applied to children versus adults, an explanation of the importance of listening and talking to the conscious victim, of making assessments, and setting priorities.

However, my highest recommendation of the book would be given for its promotion of personal safety attitudes and practices, which most of us violate from time to time.

The rationale upon which this safety oriented manual is based, can best be summarized in this introductory quote:

"First Aid strives to minimize or overcome the effects of unsafe acts or unsafe conditions which have in the past been considered uncontrollable."

*Reviewed by Cheryl Ann Lapp, graduate student, Advanced Public Health Nursing, School of Public Health, University of Minnesota.*



# When your questions involve clinical laboratory tests, turn to Widmann for guidance!

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For the eighth edition, Dr. Widmann has completely reorganized the book, making it much more practical to use. The book is now divided into sections, including Hematology, Immunology, Chemistry, and Microbiology. The full table of contents (reproduced elsewhere on this page) will show you the new organization of the book.

The author has also added a great deal of new material to this edition. The section on Immunology has been updated to include new tests and new understanding of the body's defenses against external and internal attack. The new material included on blood banking explains what happens to blood when it is stored. The section on Chemistry deals more extensively than ever with tests that are important clinically.

No matter the area of your practice, maternal-child care, primary care, or medical/surgical nursing, you'll find Widmann's **Clinical Interpretation of Laboratory Tests** a handy and reliable source of information.

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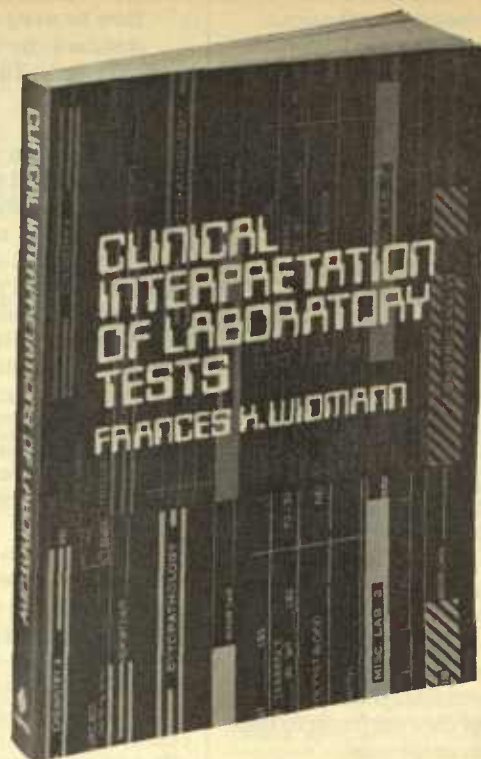
Cynthia JoAnn Leitch, editor of the journal, *The Nurse Practitioner*, and Richard V. Tinker have organized a team of 19 highly qualified nurses and doctors to produce a text ideal for today's nurse practitioner. It ranges from evaluation and management of primary care problems, and primary health care of the child, through the management of medical emergencies, and mental health in primary care, to rehabilitation. By **Cynthia JoAnn Leitch**, PhD, RN; and **Richard V. Tinker**, MD. 589 pp. Illustd. \$30.00. 1978.

### TABER'S® Cyclopedic Medical Dictionary, 13th Edition

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Edited by **Clayton L. Thomas**, MD, MPH. 1784 pp. Illustd. Thumb-indexed. \$19.00. Not thumb-indexed: \$17.50. 1977.

Prices are subject to change.



By **Frances K. Widmann**, MD, Associate Professor of Pathology, Duke University School of Medicine, Durham, North Carolina. 656 pp. Illustd. \$14.50. January 1979. Order #9322-2.

## Table of Contents

**I Hematology:** Hematologic Methods; Hemostasis and Tests of Hemostatic Function; Diseases of Red Blood Cells; Diseases of White Blood Cells; Disorders of Hemostasis. **II Immunology:** Principles of Immunology and Immunologic Testing; Serology: Selected Immunologic Tests; Immunohematology and Blood Banking. **III Chemistry:** General Chemistry; Acid-Base and Electrolyte Regulation; Serum Enzymes of Diagnostic Importance; Liver Function Tests. **IV Microbiology:** Microbiologic Examinations; Serologic Tests in Microbiology. **V Endocrine System:** The Endocrine Glands; Pregnancy. **VI Other Tests:** Urine, Feces; Sputum; Gastric and Duodenal Contents; The Cerebrospinal Fluid. Index.

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**Vulnerable infants: a psychosocial dilemma.** Edited by Jane Linker Schwartz and Lawrence H. Schwartz. 378 pages. New York. McGraw-Hill Inc., 1977.  
*Approximate price \$10.95*

The editors of *Vulnerable Infants* have compiled a volume containing twenty-one articles and editorial comment. The collection of articles contains both classic studies and more recent observations from an impressive list of contributors. As well as providing evidence of the effects of various parameters on the outcome of pregnancy and the subsequent growth and development of the high risk infant, the book draws attention to current moral, legal and ethical dilemmas encountered in the health care of high risk infants.

The focus of the book is on the psychosocial aspects surrounding high risk infancy. Although management of the problems is not the theme, the various studies, both because of their findings and the variables measured, provide a wealth of data pertinent to both preventative and management approaches.

In the introductory chapter, the editors point out the dramatic increase in the survival rate of low birth weight babies as a result of technological advances. The crisis of coping with the high risk infant and his family is thus encountered with increasing frequency by health care professionals both in hospitals and in the community. U.S. statistics are used to illustrate the scope of the problem and the economic and social costs in that country.

The remaining chapters are well organized. Each contains a group of articles dealing with one aspect of the problem preceded by an editorial comment highlighting the content of the articles and bringing findings of related research studies by other authors.

The volume is a carefully chosen selection of articles which clearly illustrates the problems, encourages further study and provides direction for health care. The articles and their extensive bibliographies provide a rich and convenient source for any professional concerned with the problems of the high-risk newborn. Many of the readings are a must for anyone involved in the planning and implementation of perinatal health care services. In addition the many questions raised by the editors and contributors call out for more research and the volume should, therefore, provide both background and impetus for further study of problems related to the vulnerable infant.

*Reviewed by J. Alison Rice, Assistant Professor, University of British Columbia, School of Nursing, Vancouver, B.C.*

**How to write meaningful nursing standards** by Elizabeth J. Mason, 355 pages. Toronto, John Wiley and Sons, 1978.

Presented in workbook format, this book is designed to help nurses write meaningful and explicit nursing standards which can be evaluated.

Three types of standards are examined within relative parameters. The type of standard is clearly defined, and information is provided on how to write the particular standard being discussed in a step-by-step format. An opportunity for practice is provided for the reader to apply the information gained and answers are also supplied so that the reader can evaluate his or her progress.

Chapters are developed independently, so that the reader can choose a starting point, without having to follow a chapter by chapter sequence.

The chapter on "Validating Standards" demonstrates some ambiguity and vagueness and at times is confusing as to procedure. In addition, although each chapter contains an introduction of content, and a summary (as well as an acknowledgement in some), there is no bibliography for references. The absence of an index also makes it difficult to locate specific information.

Despite the shortcomings, this book is of value to nurses who are concerned with developing criteria for evaluating nursing practice in all settings, and should be useful to nursing associations who are attempting to determine standards for practice.

*Reviewed by Diane Pechiulis, Associate professor, Faculty of Nursing, University of Calgary.*

## BOOKS RECEIVED

*Listing of a publication does not preclude its subsequent review. Selections for review will be made according to the interests of our readers and as space permits. All reviews are prepared on invitation.*

**Le bruit industriel; ses méfaits et son contrôle**, par Guy Lescoufflaire. Québec, Presses de l'Université Laval, 1979.

**Manuel de thérapeutique médicale**, par Nicolas V. Costriani. Traduction et adaptation de la 22e édition américaine. Paris, Edisem, 1979.

**Fertilité-contraception-avortement; guide pratique**, par École de Service social. Québec, Université Laval, 1979.

**Mieux vivre avec son enfant**, par Nicole Dumas et Danielle LeHénaf. Québec, Département de santé communautaire, 1979.

**A history of the council for the education and training of health visitors**, by Elaine Wilkie. Boston, George Allen & Unwin, c1979.

**Learning about epilepsy**, by William B. Svoboda. Baltimore, University Park Press, c1979.

**Anatomy of an illness as perceived by the patient; reflections on healing and regeneration**, by Norman Cousins. New York, W.W. Norton, c1979.

**Manual of advanced nursing**, by Lorna A. Schreiber & Marie E. Vlok. 3rd ed. Johannesburg, Juta & Co., 1979.

**Techniques infirmières: une démarche locale d'analyse du programme d'enseignement**, par Madeleine Bureau-Brien. Québec, Collège de Sherbrooke, 1979.

**Dying in an institution; nurse/patient perspectives**, by Mary Reardon Castles & Ruth Beckmann Murray. New York, Appleton-Century-Crofts, c1979.

**Cancer-causing agents; a preventive guide**, by Ruth Winter. New York, Crown Pub., c1979.

**Report of the Ninth Ross Roundtable on critical approaches to common pediatric problems in collaboration with the Ambulatory Pediatric Association.** School-related health care. Columbus, Ohio, Ross Laboratories, c1979.

**Voyager en santé sous les tropiques**, par Pierre Viens. Montréal, Le médecin du Québec, 1979.

**Naître aujourd'hui.** Montréal, Le Médecin du Québec, c1979.

**The treatment of hypertension**, edited by E.D. Freis. Baltimore, University Park Press, c1978.

**Baby surgery; nursing management and care**, by Daniel G. Young, Eleanor J. Martin & Barbara F. Weller. 2d ed. Baltimore, Ma., University Park Press, c1979.

**Alcoholism in perspective**, edited by Marcus Grant & Paul Gwinner. Baltimore, Ma., University Park Press, c1979.

**Clinical simulations in nursing practice**, by Nancy Ann Corbett & Phyllis Beveridge. Toronto, Saunders, 1980.

**Manual of pediatric nursing careplans.** Department of Nursing. The Hospital for Sick Children, Toronto, Canada. Edited by U.F. Matthews. Boston, Little, Brown, c1979.

**Research in nursing practice**, by Donna Diers. Toronto, Lippincott, c1979.

**Pharmacology and drug therapy in nursing**, by Morton J. Rodman & Dorothy W. Smith. 2d ed. Toronto, Lippincott, c1979.

**Medical-surgical nursing and related physiology**, by Jeannette E. Watson. 2d ed. Toronto, Saunders, 1979.

**The developmental therapist**, by Barbara Sharpe Banus...et al. Thorofare, N.J., Charles B. Slack, c1979.

**Alcohol and your patient; a nurse's handbook**, by Madelaine Coates & Gail Paech. Toronto, Addiction Research Foundation, 1979.

**Leadership in nursing**, edited by Marjorie Beyers. Wakefield, Ma., Nursing Resources, c1979.

**The clinical performance examination; development and implementation**, by Carrie B. Lenburg. New York, Appleton-Century-Crofts, c1979.

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## British Columbia

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**Registered Nurses** required for both acute and extended care in a 125-bed hospital in the South Okanagan. Experience in obstetrics and medical-surgical preferred. RNABC contract in effect. Apply stating qualifications and experience to: Nursing Administrator, South Okanagan General Hospital, Box 760, Oliver, British Columbia, V0H 1T0. Phone: 498-3474.

**Experienced General Duty Nurses** required for 130-bed hospital. Basic Salary \$1,305.00—\$1,542.00 per month. Policies in accordance with RNABC Contract. Residence accommodation available. Apply in writing to: Director of Nursing, Powell River General Hospital, 5871 Arbutus Avenue, Powell River, British Columbia V8A 4S3.

**Registered Nurses** required immediately for a 340-bed accredited hospital in the Central Interior of B.C. Registered Nurses interested in nursing positions at the Prince George Regional Hospital are invited to make inquiries to: Director of Personnel Services, Prince George Regional Hospital, 2000—15th Avenue, Prince George, British Columbia, V2M 1S2.

**Registered Nurses** required for permanent fulltime position at a 147-bed fully accredited regional acute care hospital in B.C. Salary at 1979 RNABC rate plus northern living allowance. One year experience preferred. Apply: Director of Nursing, Prince Rupert Regional Hospital, 1305 Summit Avenue, Prince Rupert, British Columbia, V8J 2A6. Telephone (collect) (604) 624-2171 Local 227.

**General Duty RN's or Graduate Nurses** for 54-bed Extended Care Unit located six miles from Dawson Creek. Residence accommodation available. Salary and personnel policies according to RNABC. Apply: Director of Nursing, Pouce Coupe Community Hospital, Box 98, Pouce Coupe, British Columbia or call collect (604) 786-5791.

**Experienced maternity, I.C.U./C.C.U., and Operating Room General Duty nurses** required for 103-bed accredited hospital in Northern B.C. Must be eligible for B.C. registration. Apply in writing to the: Director of Nurses, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia, V8G 2W7.

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## British Columbia

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**University of Victoria, School of Nursing.** Applications are invited for positions on the faculty of the School of Nursing, University of Victoria. The School offers a two-year post-R.N. programme leading to a B.Sc.N. and plans to develop both a basic and a master's programme. Qualifications: Master's degree required, doctorate preferred. Experience in university teaching an asset. Apply to: Director, School of Nursing, University of Victoria, P.O. Box 1700, Victoria, British Columbia V8W 2Y2.

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**Challenging Career Opportunity for Registered Nurses in Canada's North**—A 100 bed acute care hospital in Northern Manitoba which services Thompson and several small communities in the surrounding area has immediate vacancies in Pediatrics, Medicine/Surgery, Obstetrics and Critical Care. This opportunity will appeal to nurses who want to increase their existing skills or develop new skills through our comprehensive inservice program. Many of our nurses have become experienced in flight nursing. Candidates must be eligible for provincial registration as active practicing members. We offer an excellent range of benefits, including free dental plan, accident, health and group life insurance. Salary range is \$1,078 - \$1,340 per month dependent on qualifications and experience plus a remoteness allowance. Apply in writing or phone: Mr. R.L. Irvine, Director of Personnel, Thompson General Hospital, Thompson, Manitoba, R8N 0R8. Phone: (204) 677-2381.

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The Stanton Yellowknife Hospital, a 72-bed accredited, acute care hospital requires registered nurses to work in medical, surgical, pediatric, obstetrical or operating room areas. Excellent orientation and inservice education. Some furnished accommodation available. Apply: Assistant Administrator-Nursing, Stanton Yellowknife Hospital, Box 10, Yellowknife, N.W.T., X1A 2N1.

## Ontario

Applications are now being accepted by the Ontario Society for Crippled Children for **Registered Nurses, Graduate Nurses and Registered Nursing Assistants** for their Resident Summer Camps located near Collingwood, Port Colborne, Perth, Kirkland Lake and London. Ten weeks — mid June to late August, 1980. Various positions available — Supervisory, Assistant supervisory, and general cabin responsibilities. Contact: Camping and Recreation Department, 350 Rumsey Road, Toronto, Ontario M4G 1R8. (416) 425-6220, ext. 242.

**RN, GRAD or RNA, 5'6" or over and strong,** without dependents, non-smoker, for 185 lb. handicapped retired executive with stroke. Able to transfer patient to wheelchair. Live in 1/2 yr. in Toronto and 1/2 yr. in Miami. Wages: \$200.00 to \$275.00 wkly. NET plus \$90.00 wkly. bonus on most weeks in Miami. Write: M.D.C., 3532 Eglinton Avenue West, Toronto, Ontario, M6M 1V6.

## Quebec

**Registered Nurse** for summer camp in the Laurentians, mid-June to end of August. Congenial surroundings. Resident doctor. Contact: Myron Goodman, Executive Director, YM-YWHA Wooden Acres Camp, 5500 Westbury Avenue, Montreal, Quebec H3W 2W8. Telephone: (514) 737-6551, Local 51.



## Quebec

Camp Nurses required for children's summer camp in beautiful Quebec Laurentians. Mid-June to end of August. Resident M.D. Contact: Mr. Herb Finkelberg, Director of Camp B'Nai B'Rith, 5151 Cote St. Catherine Rd., Suite 203, Montreal, Quebec H3W 1M6, or telephone (514) 735-3669.

## Saskatchewan

Required immediately three full time **Registered Nurses** for 26-bed general duty active treatment hospital in northwestern Saskatchewan. Salary and benefits per current S.U.N. Contract. Apply to: Miss Theresa Ste. Marie, Director of Nursing, Riverside Memorial Union Hospital, Turtleford, Saskatchewan S0M 2Y0.

R.N.'s and R.P.N.'s (eligible for Saskatchewan registration) required for 340 fully accredited extended care hospital. For further information, contact: Personnel Department, Souris Valley Extended Care Hospital, Box 2001, Weyburn, Saskatchewan S4H 2L7.

## United States

R.N.'s U.S.A. — Dunhill with 250 offices has exciting career opportunities for both recent grads and experienced R.N.'s. Locations North, South, East and West. All fees are paid by the employer. Send your resume to: 801 Empire Building, Edmonton, Alberta, T5J 1V9.

Total patient care with all licensed personnel is our goal! **Staff RNs** currently interviewing for part-time and full-time positions. Full service, except psych, progressive 156-bed accredited acute general hospital. Located within 60 minutes from LA, the ocean, mtns., and the desert. Orientation and staff development programs. CEUs provider number. Parkview Community Hospital, 3865 Jackson Street, Riverside, California 92503. Write or call collect 714-688-2211 ext. 217. Betty Van Aernam, Director of Nursing.

**Florida Nursing Opportunities** — MRA is recruiting Registered Nurses and recent Graduates for hospital positions in cities such as Tampa, St. Petersburg, and Sarasota on the West Coast; Miami, Ft. Lauderdale and West Palm Beach on the East Coast. If you are considering a move to sunny Florida, contact our Nurse Recruiter for assistance in selecting the right hospital and city for you. We will provide complete Work Visa and State Licensure information and offer relocation hints. There is no placement fee to you. Write or call **Medical Recruiters of America, Inc.** (For West Coast) 1211 N. Westshore Blvd., Suite 205, Tampa, FL 33607 (813) 872-0202; (For East Coast) 800 N.W. 62nd St., Suite 510, Ft. Lauderdale, FL 33309 (305) 772-3680.

**RN'S** — Our Florida hospitals need you! Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. **No Fees!** Call or write: Medical Recruiters of America, 1211 N. Westshore Blvd., Suite 205, Tampa, Florida 33607 — (813) 872-0202.

**Nurses — RNs — Immediate Openings in California-Florida-Texas-Mississippi** — if you are experienced or a recent Graduate Nurse we can offer you positions with excellent salaries of up to \$1300 per month plus all benefits. Not only are there no fees to you whatsoever for placing you, but we also provide complete Visa and Licensure assistance at no cost to you. Write immediately for our application even if there are other areas of the U.S. that you are interested in. We will call you upon receipt of your application in order to arrange for hospital interviews. You can call us collect if you are an RN who is licensed by examination in Canada or a recent graduate from any Canadian School of Nursing. Windsor Nurse Placement Service, P.O. Box 1133, Great Neck, New York, 11023. (516 — 487-2818).

"Our 20th Year of World Wide Service"

## MANITABA

Department of Health and Community Services

**The School of Psychiatric Nursing,  
Selkirk Mental Health Centre  
is offering a Post - Basic Course in  
Psychiatric Nursing**

Registered Nurses currently licensed in Manitoba or eligible to be so licensed, with University credits in Introductory Psychology and Introductory Sociology.

The course is of ten months duration September through June, and includes theory and clinical experience in hospitals and community agencies, as well as six weeks nursing of the mentally retarded.

Successful completion of the program leads to eligibility for licensure with the R.P.N.A.M., as a Registered Psychiatric Nurse (R.P.N.).

For further information please write:

Director of Nursing Education  
School of Psychiatric Nursing  
Box 9600  
Selkirk, Manitoba R1A 2B5

## Before accepting any position in the U.S.A. PLEASE CALL US COLLECT

**We Can Offer You:**

- A) Selection of hospitals throughout the U.S.A.
- B) Extensive information regarding Hospital— Area. Cost of Living, etc.
- C) Complete Licensure and Visa Service

**Our Services to you are at  
absolutely no fee to you.**

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P.O. Box 1133 Great Neck, N.Y. 11023

**(516) 487-2818**

**Our 20th Year of World Wide Service**

## Waterford Hospital Career Opportunities For Registered Nurses

The Waterford Hospital, a fully accredited 400 bed Psychiatric Institution, affiliated with Memorial University School of Nursing and Medical School, has openings for Registered Nurses in all services, including new, expanded, and acute care services.

An orientation program is offered. Salary is on the scale of \$12,048 — 14,555 per annum. A Psychiatric Service Allowance of \$1,329 per annum is available in addition to basic salary. Both salary and allowance presently under review.

The Hospital is close to all amenities: shopping, transportation and recreation facilities.

Accommodations available in Hospital Residence at nominal cost.

Applications in writing should be addressed to the undersigned:

Personnel Director  
Waterford Hospital  
Waterford Bridge Road  
St. John's, Newfoundland  
A1E 4J8

Telephone Number: (709) 368-6061, ext. 341

## United States

Dallas, Houston, Corpus Christi, etc., etc., etc. The eyes of Texas beckon RN's and new grads to practice their profession in one of the most prosperous areas of the U.S. We represent all size hospitals in virtually every Texas and Southwest U.S. City. Excellent salaries and paid relocation expenses are just two of many super benefits offered. We will visit many Canadian cities soon to interview and hire. So we may know of your interest, won't you contact us today? Call or write: Ms. Kennedy, P.O. Box 5844, Arlington, Texas 76011. (214) 647-0077.

**Come to Texas** — Baptist Hospital of Southeast Texas is a 400-bed growth oriented organization looking for a few good R.N.'s. We feel that we can offer you the challenge and opportunity to develop and continue your professional growth. We are located in Beaumont, a city of 150,000 with a small town atmosphere but the convenience of the large city. We're 30 minutes from the Gulf of Mexico and surrounded by beautiful trees and inland lakes. Baptist Hospital has a progress salary plan plus a liberal fringe package. We will provide your immigration paperwork cost plus airfare to relocate. For additional information, contact: Personnel Administration, Baptist Hospital of Southeast Texas, Inc., P.O. Drawer 1591, Beaumont, Texas 77704. An affirmative action employer.

**Excitement:** Come and join us for year around excitement on the border, by the sea, an unbeatable combination. Enjoy the sandy beaches of So. Padre Island or the unique cultures of Old Mexico. Our new 117-bed, acute care hospital offers the experienced nurse and the newly graduated nurse an array of opportunities. We have immediate openings in all areas. Excellent salary and fringe benefits. We invite you to share the challenge ahead. Assistance with travel expenses. **Write or call collect:** Joe R. Lacher, RN, Director of Nurses, Valley Community Hospital, P.O. Box 4695, Brownsville, Texas 78521; (512) 831-9611.

**Registered Nurses.** We invite you to join our health care team at Leon County Memorial Hospital, Inc., a 36 bed acute care facility in Buffalo, Texas, located in the Lone Star State's scenic country hillside of east Central Texas. We will provide you with a challenging professional opportunity as a nurse involved in our high level, quality patient care programs. Excellent starting salary; equitable shift differentials; group employee benefits; educational opportunities; and reasonable relocation expenses. H-1 Visa assistance provided. Please contact: Director of Nurses, P.O. Box 159, Buffalo, Texas 75831. Phone 214/322-4231.

**Nurses — RNs — A choice of locations with emphasis on the Sunbelt.** You must be licensed by examination in Canada. We prepare Visa forms and provide assistance with licensure at no cost to you. **Write for a free job market survey Or call collect (713) 789-1550. Marilyn Blaker, Medex, 5805 Richmond, Houston, Texas 77057. All fees employer paid.**

**Nurse Midwives — Overseas:** Project HOPE seeks a Midwife Nurse Educator for Egypt. This person would need a Master's Degree, Midwifery Certification and 2-5 years teaching experience. It will offer the challenge of working with an Egyptian counterpart in curriculum development and expansion of the midwifery program. Project HOPE provides excellent benefits, negotiable salary, travel, shipping and storage. Send resume to: Personnel Department, Project HOPE, Millwood, Virginia 22646. E.O.E.

## Miscellaneous

I wish to contact any members of the student nurses' class at The Toronto East General Hospital, Toronto, Ontario, for the years 1960 to 1963. Write to: Basement Suite, 424 East 37th Avenue, Vancouver, British Columbia, V5W 1E9.



# IMPORTANT MEMO

**To:** Registered Nurse Applicants For Overseas Jobs  
**From:** Hospital Corporation International  
**Subject:** Some Advice On Seeking Employment In The Field Of International Nursing.

Many organizations are offering overseas job opportunities in the health and hospital field these days. If you are interested and seriously considering an overseas or international assignment, here are some important points to consider and questions to ask — before and at your interview:

1

**Who is doing the interviewing and recruiting? What is their experience and background?**  
Make sure you are dealing with a reputable organization that is a true representative of your prospective employer. Be sure they have first hand knowledge of the location and facilities where you'd be living and working.

2

**Will I have to pay an employment fee? If so, for what and why?**  
Some independent agencies will charge you a sizeable fee just to send your resume somewhere else and can make no commitment to you. Other organizations do their own recruiting or can make commitments and they won't charge you an employment fee.

3

**What kind of organization or company am I dealing with? What is its primary business?**  
If it isn't the Health Care Business, first and foremost, you may want to investigate further: What are their qualifications, experience, standards, quality, etc?

**How realistic is the information and how much is offered about the job, the working conditions, culture, etc?**

If it all sounds exciting, glamorous, and positive, then the picture isn't realistic, it's "rose-colored". It *can* be adventurous and rewarding, but there are day to day drawbacks, frustrations, and difficulties to consider before you decide to go. And you should be told about *all* the details — don't accept generalizations.

4

**Will I be offered any assistance in preparing for overseas relocation, employment, and adapting to the new environment?**

Experienced, reputable organizations will show concern for you as an individual — and for your ultimate success — by assisting you with pre-departure processing requirements and preparations and by providing comprehensive pre-departure and post-arrival orientation programs.

5

**Will I be offered any assistance to relocate in another job when my contract is finished?**

Find out if the company can help you "get back in touch" after being away from home for two or more years. It's an important point that many individuals overlook — and so do many companies.

6

Hospital Corporation International, a member of the Hospital Corporation of America Group, is one of the most experienced and professional organizations providing international recruitment and human resource services in the health care and hospital related field.

If you are thinking about an overseas assignment, we invite you to explore the possibilities by exploring Hospital Corporation International. Ask us the questions; we'll give you the answers. You owe it to yourself.

If you are interested and would like more information, please send your resume to:

**International Human Resource Management (7)**

**Hospital Corporation International**

**One Park Plaza**

**Nashville, Tennessee 37203**

**HOSPITAL  
CORPORATION  
INTERNATIONAL**

**An Equal Opportunity Employer**



## Centracare Saint John, Inc.

This 500-bed Psychiatric Hospital is inviting applications from:

### Registered Nurses

for

All Units – Acute, Rehabilitation, Geriatric and Infirmary

### Qualifications Required:

Graduation from an approved School of Nursing, registered or eligible for registration in the Province of New Brunswick. Post-graduate preparation in Psychiatric Nursing would be an asset. Competence in English is essential.

### Salary:

\$11,208 to \$16,740 per annum, commensurate with qualifications and experience.

### Benefits:

As per the Collective Agreement, including pension plan, sick leave and vacation leave.

### Apply To:

Personnel Office  
Centracare Saint John, Inc.  
P.O. Box 3220  
Saint John  
New Brunswick  
E2M 4H7

Competition No. CSJ 79-28

## Assistant Supervisor Psychiatric Nursing

Applications are being accepted for the above position. The successful applicant will provide innovative, creative leadership in the planning, development, implementation and evaluation of quality assurance and staff development programs for the department. The incumbent will also give clinical supervision in the areas of special expertise.

Applicants must be eligible for registration in British Columbia. MSN degree is preferred and BSN degree is required. Demonstrated administrative ability, including skills in leadership and interpersonal relations is required, plus expert specialized clinical nursing skills. Advanced competence in nursing education is essential. Salary and benefits as per RNABC contract.

Please submit applications to:

Mrs. J. MacPhail  
Employee Relations Department  
Vancouver General Hospital  
855 W. 12th Avenue  
Vancouver, B.C.  
V5Z 1M9

## "Tomorrow's" Nursing...

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Graduate Of \_\_\_\_\_  
AA \_\_\_\_\_ BS \_\_\_\_\_ Dip \_\_\_\_\_ Yr \_\_\_\_\_  
Area of Interest \_\_\_\_\_  
CN180



## ...is a short drive away from Fisherman's Wharf

The colorful tastes, sights and sounds of Fisherman's Wharf are some of the fascinating things you'll find, a short drive from Stanford University Medical Center.

You will also find "tomorrow's" nursing today in an exciting teaching hospital where non-clinical personnel handle administrative and support tasks so you can concentrate on progressive nursing. You can apply new techniques, participate in research and work with leading authorities in every medical specialty.

We'd like you to know more about our career development programs and our excellent compensation package which includes an innovative time-off program. For additional information, send the coupon to Nurse Recruiter, Personnel Department, Stanford University Hospital, Stanford, CA 94305. Or call collect to (415) 497-7330. For immediate consideration, send your resume and salary requirements. We are an affirmative action, equal opportunity employer, male & female.



**Stanford University  
Medical Center**



## Are You a Nurse?

### Here's an Opportunity To Be One.

#### Primary Nursing

.....at the New Regional Hospital means having direct responsibility for the nursing care of your patient, his family, and working with the doctor as a colleague.

#### Accountability

.....as a primary nurse means the outcome of your patient's care is the measure of your effectiveness.

#### Satisfaction

.....results from your role as a professional and the significant part you play in the care of your patient.

**PUT IT TOGETHER** with the new 300 bed Fort McMurray Regional Hospital Opening in November, 1979.

Want to know more about your opportunities in our **total patient care** facilities?

Call Penny Albers at (403) 743-3381

or

Write for an information package:

Personnel Department  
Fort McMurray Regional Hospital  
Fort McMurray, Alberta  
T9H 1P2

## OPPORTUNITY

# Alberta

### Nurses

Applications are invited for positions at Alberta Hospital, Edmonton, a 650 bed active treatment psychiatric hospital, located 4 km. outside of Edmonton.

Successful candidates must be graduates from a recognized School of Nursing and eligible for registration in their professional association; willing to work shifts. Vacancies exist in Admissions, Forensic, Rehabilitation, and Geriatric Services.

**Note:** Transportation is available to and from Edmonton. Accommodation is available in the Staff Residence.

Salary \$1,229 — \$1,445 per month (Starting salary based on experience and education)

Competition #9184-9

This competition will remain open until a suitable candidate has been selected.

Qualified persons are invited to phone, write or submit applications to:

Personnel Administrator  
Alberta Hospital, Edmonton  
Box 307, Edmonton, Alberta  
T5J 2J7  
Telephone: (403) 973-2213

## EXPERIENCED RN'S & NEW GRADS

### "THE PERFECT OPPORTUNITY"

Saint Anthony Hospital, located in Columbus, Ohio.

This 400-bed acute care facility offers excellent opportunities for furthering your nursing career.

**No Contracts to Sign**

**Rotating Shifts**

**Air Fare Paid**

**One Month Free Accommodations**

**Plus Exciting Challenges**

Saint Anthony, a medical-surgical institution, has a complete range of services, including:

- Open Heart Surgery
- Intensive and Coronary Care
- Definitive Observation Unit
- Renal Dialysis
- Diagnostic and Therapeutic Radiology
- 24 Hour Emergency Department

**Don't wait, call or write immediately.**

Make the change to an institution that lets you be what you want to be. For further information, call our Nurse Recruiter, Norma Shore, Collect.

**EXCLUSIVE CANADIAN REPRESENTATIVES  
RECRUITING REGISTERED NURSES INC.**



1200 Lawrence Avenue East  
Suite 301, Don Mills  
Ontario M3A 1C1  
Telephone: (416) 449-5883



## Nursing in the Sunny Palm Beaches

Picture yourself in the sunny Palm Beaches working at the most prestigious hospital in Florida. Good Samaritan Hospital has maintained the tradition of being the first in the latest hospital services and facilities. Our good name and outstanding history attest to our success.

A 326 bed, J.C.A.H. accredited hospital offering attractive salaries and benefits including:

- Active in-service orientation
- Continuing educational programs
- 37 1/2 hour week
- 5 day week
- No shift rotation
- Education and experience differential
- Fully paid Blue Cross/Blue Shield
- Shift differential and other employee benefits
- Seasonal employment welcome
- Patient-mix 90% under age 65

We will sponsor the appropriate employment Visa for qualified applicants. Attractive efficiency apartments available at far below commercial rates, overlooking the beautiful Lake Worth and located across the boulevard from the hospital.

Write:

Director of Personnel (305) 655-5511  
Good Samaritan Hospital  
Flagler Drive at Palm Beach Lakes Blvd.  
P.O. Box 3166  
West Palm Beach, Fla. 33402

## Head Nurse Coronary Care Unit

Applications are being accepted for the above position. The unit consists of a 3 bed intensive care unit, 10 acute care beds and 8 sub-acute care beds. The successful applicant will be involved in the planning and development of a new Coronary Care Unit.

Applicants should have a minimum of 2 years previous experience in a related clinical area plus previous administrative experience and preferably hold a BSN. Salary scale and benefits according to the RNABC agreement. Please submit applications to:

Mrs. J. MacPhail  
Employee Relations Department  
Vancouver General Hospital  
855 W. 12th Avenue  
Vancouver, B.C.  
V5Z 1M9

## Advertising rates

For All  
Classified Advertising

\$20.00 for 6 lines or less  
\$3.00 for each additional line

Rates for display advertisements on request.

Closing date for copy and cancellation is 8 weeks prior to 1st day of publication month.

The Canadian Nurses Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

*The Canadian Nurse*  
50 The Driveway  
Ottawa, Ontario  
K2P 1E2



## Health Sciences Centre Winnipeg, Manitoba

invites applications for the position of

### Assistant Director Maternal-Child Nursing

This position is open to females and males.

The Health Sciences Centre, one of the continent's largest health care facilities with 1300 beds, is Manitoba's principal referral institution for complex health problems and the Province's major hospital for teaching and research.

The incumbent shall be responsible for the administration of nursing services in the Women's Centre, the major high risk referral unit for Obstetrics, Neonatology and Gynaecology. The Women's Centre has approximately 3500 deliveries a year, and 48 gynaecology beds.

We are seeking an individual who can co-ordinate nursing with medical programmes in implementing a common philosophy of care, who can participate in the planning of new facilities, who can direct and develop nursing staff in the use of systems which affect patient care and can develop strong interpersonal relationships.

Candidates require a B.N. (M.N. preferred), demonstrated success in an administrative position, a background in the above clinical specialties and registration or eligible for registration in Manitoba.

Interested persons should apply in writing including a complete resume detailing education and experience to:

Manager Employment & Training  
Health Sciences Centre  
700 William Avenue  
Winnipeg, Manitoba R3E 0Z3

## Registered Nurses

Come to work in scenic Corner Brook!

Registered nurses are needed for this 350 bed Regional General Hospital, with detached 60 bed Special Care Unit, serving the West Coast of Newfoundland.

The hospital offers good fringe benefits such as four weeks annual vacation and eight statutory holidays plus birthday holiday. In addition there is a hospital pension plan and a group insurance plan for all permanent employees.

Accommodation and assistance with transportation is available.

Negotiated Salary Scale:

1 January, 1979 — \$12,771.00 — 15,429.00  
1 January, 1980 — \$13,410.00 — 16,199.00  
(Contract not yet signed)

Service Credits recognized.

Interested applicants apply to:

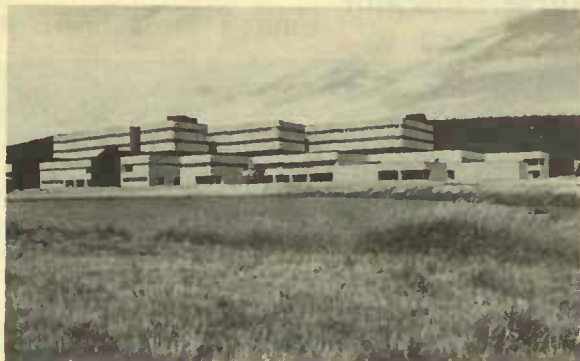
Mrs. Shirley M. Dunphy  
Director of Personnel  
Western Memorial Regional Hospital  
P.O. Box 2005  
Corner Brook, Newfoundland  
A2H 6J7



## **A Completely Modern Teaching Hospital**

### **Requires**

### **Registered Nurses**



This 500 bed general hospital is the major teaching facility for the Medical School of Memorial University of Newfoundland.

#### **Services offered -**

Critical Care, Medical, Surgical Coronary Care, General Surgery, Urology, Gynecology, Medicine, Nephrology, Clinical Teaching, Neurosciences, Cardiology, Cardiovascular Surgery, Orthopedics, Hemodialysis (kidney transplants), Emergency and Out Patient Services, active Rehabilitation Program (adult).

The Staff Development and Training Department offers ongoing lectures and demonstrations in addition to a 6 month diploma course (twice yearly) in — Critical Care Nursing, Neurosciences, Operating Room Nursing.

Located in St. John's, Newfoundland — the oldest city in North America with a population of 120,000, offering cultural and recreation activities in a friendly atmosphere.

Fishing, hunting, boating available approximately 10-14 miles outside the city.

For information regarding salary and relocation expenses and other conditions of employment write or call -

**Miss Dorothy Mills  
Staffing Officer - Nursing  
The General Hospital  
Prince Philip Drive  
St. John's, Nfld.  
A1B 3V6**

**Telephone # (709) 737-6450**

# **MANIT BA**

**DEPARTMENT OF EDUCATION**

This position is open to both men and women.  
Apply in writing referring to Competition  
Number VT 749 immediately.

### **Instructor/Curriculum**

### **Co-ordinator**

### **Diploma Nursing (Term Position)**

The Department of Education, Keewatin Community College, The Pas, is currently developing a Diploma Nursing program to train northern residents who, upon completion, will be eligible to meet M.A.R.N. registration requirements. The focus of the program will be expertise required to meet health needs of northern Manitobans. The Instructor/Curriculum Co-ordinator will be responsible for subsequent curriculum development. She/he will also co-ordinate the implementation of the program; target date September 1980. Following implementation she/he will co-ordinate program activities plus carry out instructional activities.

Master's Degree preferred, or a Bachelor of Nursing with relevant experience acceptable.

Salary Range: \$17,759 - \$26,496 per annum (Plus Remoteness Allowance)

**Personnel Department  
Manitoba Community Colleges  
Room C-416  
2055 Notre Dame Avenue  
Winnipeg, Manitoba  
R3H 0J9**





## University of Western Ontario Faculty of Nursing

Applications are invited for teaching positions in undergraduate and graduate programs. Rank Open.

Master's or doctorate degree required. Preference will be given to candidates with teaching experience and clinical specialization. Candidates must be eligible for registration in Ontario.

Salary commensurate with preparation and in accordance with the University of Western Ontario policies. Appointments are subject to availability of funds.

Send complete resume to:

Dr. Beverlee Cox, Dean  
Faculty of Nursing  
Health Sciences Addition  
The University of Western Ontario  
London, Ontario. N6A 5C1

## Nursing Opportunities in Vancouver Vancouver General Hospital

If you are a Registered Nurse in search of a change and a challenge — look into nursing opportunities at Vancouver General Hospital, B.C.'s major medical centre on Canada's unconventional West Coast. Staffing expansion has resulted in many new nursing positions at all levels, including:

**General Duty (\$1305. - 1542.00 per mo.)**

**Nurse Clinician**

**Nurse Educator**

**Supervisor**

Recent graduates and experienced professionals alike will find a wide variety of positions available which could provide the opportunity you've been looking for.

For those with an interest in specialization, challenges await in many areas such as:

**Neonatology Nursing**

**Intensive Care**

**(General & Neurosurgical)**

**Inservice Education**

**Cardio-Thoracic Surgery**

**Coronary Care Unit**

**Burn Unit**

**Hyperalimentation**

**Paediatrics**

**Program**

**Renal Dialysis & Transplantation**

If you are a Nurse considering a move please submit resume to:

Mrs. J. MacPhail  
Employee Relations  
Vancouver General Hospital  
855 West 12th Avenue  
Vancouver, B.C. V5Z 1M9

## Registered Nurses

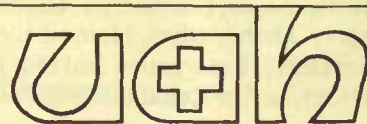
1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including:

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education Programs.  
Post Graduate Clinical Courses in Cardiovascular—  
Intensive Care Nursing and Operating Room Nursing.

Apply to:

Recruitment Officer — Nursing  
University of Alberta Hospital  
8440 — 112th Street  
Edmonton, Alberta  
T6G 2B7



## University of Alberta Hospital

Edmonton, Alberta



# Health Sciences Centre Intensive Care Nursing

## ■ Myocardial Infarction

- |                       |                            |
|-----------------------|----------------------------|
| ■ Arrhythmias         | ■ Neurological Dysfunction |
| ■ Renal Failure       | ■ Trauma                   |
| ■ Respiratory Failure | ■ Shock                    |



**MED. OR SURG. INTENSIVE CARE UNITS  
IN A 1,400 BED UNIVERSITY-AFFILIATED  
HOSPITAL**

**Offer**

**A CLINICAL COURSE  
SPONSORED JOINTLY WITH THE  
ST. BONIFACE HOSP. IN INTENSIVE  
CARE NURSING FOR ALL REGISTERED  
NURSES IN THE INTENSIVE CARE UNITS**

### **OPPORTUNITIES TO LEARN —**

- Nursing care of critically ill
- Resuscitative measures
- Use of monitoring and other advanced equipment
- Multidisciplinary approach

### **THROUGH —**

- Planned orientation
- Supervised clinical experience
- Continuing education program
- Concentrated study and hard work

**FOR FURTHER INFORMATION WRITE TO:**

**Course Co-ordinator  
Intensive Care Nursing  
Health Sciences Centre GH601  
700 William Avenue  
Winnipeg, Manitoba R3E 0Z3**

## **Dalhousie University School of Nursing Halifax, Nova Scotia, Canada**

**Faculty Positions Available July 1, 1980**

### **Graduate Programme**

Doctorate in Nursing and experience in practice, teaching, and research a requirement. Clinical expertise in care of adults (medical/surgical) a necessity.

### **Undergraduate Programmes**

Conceptually based curriculum for basic and registered nurse students.

Positions available for faculty with experience in:

- a) community health nursing
- b) maternal-child care nursing
- c) fundamentals of health and basic nursing
- d) community and mental health nursing

**Qualifications:** Masters in Nursing a requirement, Doctorate degree desirable. Salary and academic rank will depend on qualification and experience. These positions are subject to budgetary approval.

Applicants should send curriculum vitae, and names of three referees to:

**Margaret L. Bradley  
Acting Director  
School of Nursing  
Dalhousie University  
Halifax, Nova Scotia  
B3H 3J5**

## **THE UNIVERSITY OF CALGARY**

### **FACULTY OF NURSING**

Applications are invited from nurses with doctoral or master's degrees for the following appointments:

- i) Chairman of the Baccalaureate Degree Programme with experience in programme planning, curriculum development and team leadership
- ii) Faculty positions for nurses with advanced clinical preparation in:
  - medical-surgical nursing
  - mental health-psychiatric nursing
  - parent-child nursing
  - community health nursing

A Master of Nursing Degree programme is at an advanced planning stage.

Salary and rank will be commensurate with education and experience. Applications with a curriculum vitae and the names and addresses of three referees should be sent to Dr. Margaret Scott Wright, Dean, Faculty of Nursing, The University of Calgary, 2920 — 24th Ave. N.W., Calgary, Alberta, T2N 1N4.





## **Canadian Lung Association Nursing Fellowship**

The Canadian Lung Association offers Nursing Fellowship awards up to the amount of \$8,500.00 per year for Masters' or Post Masters' study in the clinical specialty of pulmonary nursing at an approved University.

Completed applications must be received by February 8th to be eligible for the 1980-81 allocation.

For further information and application form please write to:

**The Canadian Lung Association**  
75 Albert Street  
Suite 908  
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## **University of Ottawa School of Nursing**

Positions available for the 1980-81 academic year in:

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Doctorate or Master's degree in clinical specialty and teaching experience required. Preference will be given to bilingual candidates (French and English). Salary commensurate with preparation.

Send curriculum vitae and references as soon as possible to:

**The Director**  
School of Nursing  
Faculty of Health Sciences  
University of Ottawa  
770 King Edward Avenue  
Ottawa, Ontario K1N 6N5

## **McMaster University Educational Program For Nurses In Primary Care**

McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

**Requirements** Current Canadian Registration. Preceptorship from a medical practitioner. At least one year of work experience, preferably in primary care.

For further information write to:

**Mona Callin, Director**  
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Telephone: 532-7711,  
Extension 78

## **University Faculty**

Applications are invited for clinical faculty positions in an integrated baccalaureate program. Subject to budgetary approval, positions will probably be available for the 1980-81 academic year in the fields of community, long term care, maternal-child and Psychiatric nursing. Candidates should have at least a Master's degree, demonstrated clinical proficiency, teaching and scholarly capabilities. Eligibility for registration with the College of Nurses of Ontario is essential. Candidates of both sexes are equally encouraged to apply.

Salary and rank are negotiable and commensurate with qualifications and professional achievement.

Interested persons should send a full resume and the names of three professional referees to:

**A. J. Baumgart, Dean**  
School of Nursing  
Queen's University  
Kingston, Ontario K7L 3N6

Closing date of applications: April 1, 1980.

## **Psychiatric Nursing Post Diploma Program For Registered Nurses**

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Winter program begins February 4, 1980  
Fall program begins September 2, 1980.

For further information contact:

**Michelle Nichols**  
Department Head  
Health Sciences Division  
Durham College  
P.O. Box 385  
Oshawa, Ontario L1H 7L7

## **Foothills Hospital, Calgary, Al berta**

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Co-ordinator of In-service Education  
Foothills Hospital  
1403 29 St. N.W. Calgary, Alberta  
T2N 2T9

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For further information contact the:

**Personnel Department**  
Prince George Regional Hospital  
2000 - 15th Avenue  
Prince George, British Columbia  
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## **Director of Nursing**

Applications are invited for the above position in a 45-bed general hospital located in the Saint John River Valley, 90 miles northwest of Fredericton, New Brunswick.

The successful applicant will be responsible for planning, organization, and administration of the hospital's nursing service.

**Qualifications:** Candidates should preferably possess a B.Sc.N. but equivalent combination of nursing administration education and experience will be considered.

Apply with complete resume to:

**D. F. MacIver**  
Administrator  
Northern Carleton Hospital  
P. O. Box 95  
Bath, New Brunswick E0J 1E0



## Head Nurse – Medical Nursing Vancouver General Hospital

Applications are invited for the above position. The successful candidate will be responsible for providing innovative and creative leadership in the development of clinical practice within the unit by teaching, consulting and demonstrating specialized nursing skills. She/He is responsible for the quality of nursing care and the nursing administration of the unit.

The incumbent must be eligible for registration in B.C. and have experience in the specific clinical field, hold a BSN or equivalent post basic education. This person must demonstrate skill in leadership and interpersonal relations.

Salary and benefits in accordance with the RNABC contract.

Please submit resume to:

Mrs. J. MacPhail  
Employee Relations Department  
Vancouver General Hospital  
855 W. 12th Avenue  
Vancouver, B.C.  
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## Government of Newfoundland & Labrador

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Ottawa, Ontario K1A 0L3

Name .....

Address .....

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# calendar

## January

**The Faculty of Nursing, University of Toronto** is offering the following courses in early 1980; Anatomy and Physiology: The Cardiac System, Wednesday evening, January 16-30. Anatomy and Physiology: The Nervous System, Thursday evening, January 17-31. Group Dynamics and Group Process, Monday evening, January 28-March 27. Anatomy and Physiology: The Respiratory System and Acid Base Balance, Thursday evening, February 7-28. Anatomy and Physiology: The Renal System and Fluids and Electrolytes, Thursday evening, March 6-27. Health Assessment Week, February 18-22. Quality Assurance: The Use of the Nursing Audit, March 6-7, 1980. Contact: *Mrs. Dorothy Miles, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario, M5S 1A1.*

## February

Two 16-week post-Diploma Certificate Programs in Psychiatric nursing are being offered by Durham College and Whitby Psychiatric Hospital February 4 to May 23, 1980 and September 2 to December 19, 1980. For more information on this full time day course contact: *Durham College of Applied Arts and Technology, Registrar's Department, P.O. Box 385, Oshawa, Ontario, L1H 7L7, telephone 576-0210, ext. 342.*

**Nursing Care of the Sick Newborn**, current concepts of neonatal care; a five day program, a choice of: February 11-15, April 14-18 or June 9-13. Contact: *B. Cragg, Co-ordinator, Nursing Education, The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1X8.*

## March

**The Nurses Practitioners Association of Ontario** will be holding a workshop "Challenge of the '80's", March 27 and 28 at the Holiday Inn, downtown Toronto. Contact: *Trudie Tumber, 1132 Havendale Blvd., Burlington, Ontario, L7P 3E3, telephone 845-9430, ext. 254.*

**Therapeutic Compliance, Generalization and Maintenance** is the topic of the Twelfth Banff International Conference on Behavioral Medicine to be held March 16-20, 1980, Banff, Alberta. Contact: *Park Davidson, Department of Psychology, University of British Columbia, Vancouver, B.C., V6T 1W5.*

**The Third Annual Symposium on Patient Education** organized by The Johns Hopkins University School of Hygiene and Public Health, will be held March 26-30, 1980. Contact: *Ivan Barofsky, Hampton House 654, The Johns Hopkins University, School of Hygiene and Public Health, Baltimore, Maryland.*

## Looking Ahead

"**Interdisciplinary Approaches to Mental Health**" will be the theme of the 57th annual meeting of the American Orthopsychiatric Association to be held April 7-11, at the Sheraton Centre Hotel, Toronto. Contact: *American Orthopsychiatric Association, 1775 Broadway, New York, N.Y. 10019.*

The fifth Annual Congress of the **Oncology Nursing Society** will be held May 28-30 at the Sheraton Harbor Island Hotel in San Diego, CA 92101. Contact: *Nancy Berkowitz, Oncology Nursing Society, 701 Washington Rd., Pittsburgh, PA 15228.*

**Perspectives In Psychiatric Care '80**, first national psychiatric/mental health nursing conference, to be held at the Fairmont Hotel, Wakefield, MA, May 28-31, 1980. Contact: *Carol Forsythe, Nurse Educator, 12 Lakeside Park, Wakefield, MA 01880.*

The fifth **Canadian Summer Workshop in Electrocardiography** sponsored by the Rogers Heart Foundation will be held May 3-6 at the Hotel MacDonald, Edmonton, Alberta. Contact: *Anne S. Criss, Executive Coordinator, Rogers Heart Foundation, 601 12th St. N., St. Petersburg, FL 33705.*

All graduates of **Highland View Hospital**, Amherst, Nova Scotia are invited to attend a reunion tentatively planned for July 11 to 13. All interested in attending are asked to contact: *The Reunion Committee, c/o 48 Regent St., Amherst, Nova Scotia, B4H 3T1.*

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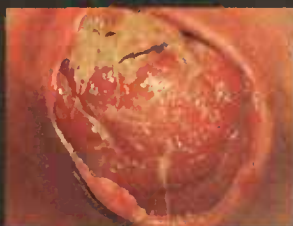
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Day 14 Ulcer healing after Debrisan discontinued.



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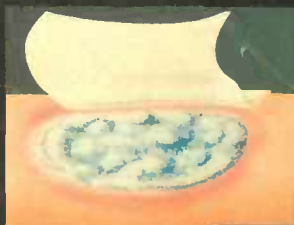
Day 7 Surgically debrided before Debrisan therapy and after 7 days, infection controlled.



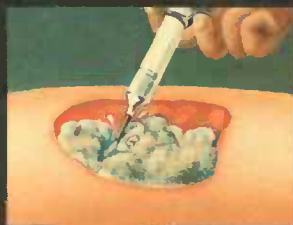
Day 28 Appearance on healing.



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#### References

1. Lim T.T., Michaels M., Enrgan J.J., *Angiology* 29:3, Sept 1978
2. Bewick M., Anderson A., *Clin Trials* 15:4, 1978
3. Soul J., Brit J. Clin Pract., 32:6, June 1978
4. DiMascio S.R., *Decubitus Care A New Approach: A Nursing Responsibility*, on file at Pharmacia (Canada) Ltd.

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Full information is published in the Compendium of Pharmaceuticals and Specialties and available on request from Schering Canada Inc., Pointe Claire, Quebec H9R 1E4

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- The syndrome of inappropriate antidiuretic hormone secretion
- Biofeedback, does it work?

# The Canadian Nurse

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Is the solitary skier so strikingly silhouetted on this month's cover aware of the dangers of hypothermia? Does he know that hypothermia is an all-to-often overloaded feature of our Canadian Winters? For that matter, what do you know about hypothermia? Our special feature begins on page 23 of this issue. (Cover photo courtesy of NFB Photothèque ONF).

# The Canadian Nurse

February 1980

Volume 76, Number 2

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Canadian Nurses Association, 50 The Driveway, Ottawa, Canada, K2P 1E2.



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The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of The Canadian Nurse. A biographical statement and return address should accompany all manuscripts.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

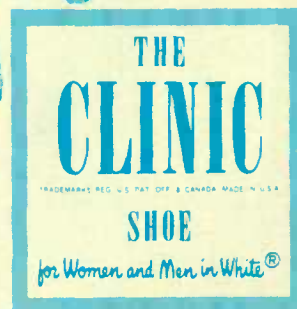
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# NOW FOR MEN IN WHITE



THE CLINIC SHOEMAKERS • Dept. CN-2, 7912 Bonhomme Ave. • St. Louis, Mo. 63105



# perspective

"Good nursing saves lives." There it is, in a nutshell. But what, exactly, is good nursing? Certainly there's more involved than simply knowing what has to be done and following correct procedures.

"Good" nursing is good from three points of view: it affords satisfaction to the nurse as a practitioner of her profession, to the patient as the recipient of her care and to the family of the patient whose care they have relinquished to that nurse.

It was this triangular relationship between nurse, patient and family that Laura Barry, the author of next month's feature article on Guillain-Barré Syndrome, set out to investigate. The article is based on work she carried out in order to meet the requirements of a post basic program in neurological and neurosurgical nursing she was enrolled in at the time.

*Watch for and read "The Guillain-Barré Syndrome", in your March issue of The Canadian Nurse.*

The comment that "Good nursing saves lives" was made by the father of the patient, Linda, whose illness and subsequent hospitalization provided material for her study. When Laura set out to write her paper she decided that the aspect of Linda's case that interested her most was the dynamics of the relationship that existed between the patient Linda, Linda's family and the nurses who cared for her. So she wrote to all of them, explaining her project and asking for their interpretation of what had happened during the three weeks that Linda was in hospital.

When she wrote to her colleagues this is what she said: "I would like you to think back to the time when Linda was a patient. As I recall, the nurse-patient-family relationship did become quite

strained at times...Why did things deteriorate between Linda and ourselves, as well as her parents? There were times when the relationship was good. Why was that? How did we make things better? What did we do that made things worse?"

Establishing a caring relationship with a patient is never easy. One of the nurses Laura talked to during her project listed some of the problems she had recognized in caring for Linda:

- inability to understand what the patient is trying to communicate
- inability to alleviate a patient's fears
- difficulty in making a patient physically comfortable
- knowing that the patient depends on you for survival
- helping the patient to develop confidence in other staff members.

All of the nurses she interviewed recognized the need for peer support, and the benefits to be gained from nursing conferences: "By talking with their peers, nurses come to realize that it is alright to get angry and frustrated at times. They realize they need not feel guilty about these feelings...Nurses are human and everyone has bad days. It is comforting to know that you are not alone. A nursing conference can give a nurse the encouragement she needs to go out and try one more time."

Linda's comment on her perception of the nurse-patient relationship is instructive: "The most important thing to remember is that you are dealing with a human being, not a patient. A human being has moods...sometimes everything is okay and you are in a good mood but sometimes things will make you depressed or frustrated and therefore nurses should be able to pick up on vibrations and react accordingly."

Good nurses, as we all know by now, are good

communicators. Linda says: "Talking to the patient like a person is a thing some of the nurses did but not all. To feel a part of the world, you need to know what is happening in the news and life in general. A patient needs to feel a part of the outside world."

When a family abandons one of its members to the ministrations of hospital staff, they do so with mixed feelings. Gertrud Ujhely put it this way: "Those who assumed quite a bit of responsibility before for their relatives who are now ill, as a wife would for her husband or a mother for her child, are liable to feel especially helpless now that the nurse has taken over so exclusively and efficiently...They fight down their tears, which are a mixture of concern about the outcome of the illness, their own helplessness and their rage against the efficient machine in white who has taken over as if the patient had always belonged to her—as if they, the relatives, had never played any role in the patient's life."

Good nursing involves recognition of the contribution that the family can make. As Linda commented: "My family played a very big part in my time in hospital and, if the family is willing, I think they should be included in most aspects of the hospitalization."

It also involves recognition of the nurse's role as leader in this triangle of nurse-family-patient. Linda's father had this to say: "It was the nurses that helped her and us keep up our spirits. They were calm and always optimistic. They had humor and sympathy. They gave out courage and hope. They exuded confidence and faith."

Listen to Linda's father again: "Good nursing saves lives. The non-medical aspect is enlisting all the help you can get from the patient, the family and friends and then with you (the nurse) as the focal point, willing the patient

to live with all the strength that you can muster...All Linda's nurses in Intensive Care did just that: they cared—intensively." M.A.B.



Seventy-five years ago next month, in March 1905, Vol. 1, No. 1 of *The Canadian Nurse* rolled off the press and into the eager hands of the small group of graduate nurses responsible for its appearance. "Devoted to the interests of the nursing profession in Canada, and to the protection of the public," its founders were staunch advocates of legislation enabling properly qualified nurses to be registered by law.

Most of them were graduates of Toronto General Hospital School of Nursing. The decision to undertake publication of a journal for nurses had been taken at a meeting of their Alumnae Association three months earlier; members approved by a standing vote a resolution that: "We undertake the Journal, placing our pin on the cover, and that while keeping the management in our own hands we make the other Alumnae Associations feel they are welcome to work with us."

Within six months, the business manager was able to report that the venture was an "undoubted success" and plans were already underway to enlarge the quarterly to "a Dominion journal, produced monthly".

In March, as part of its anniversary celebrations, CNJ takes a look at those early journals, as well as a look ahead to the year 2000.



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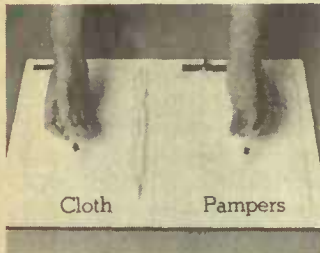
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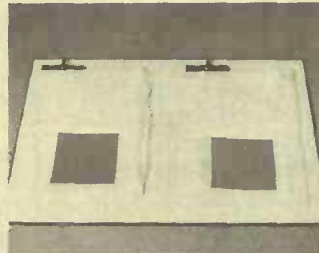
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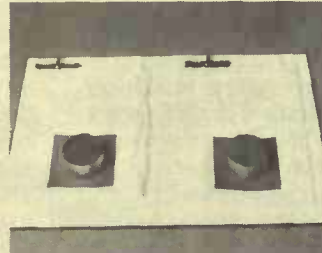


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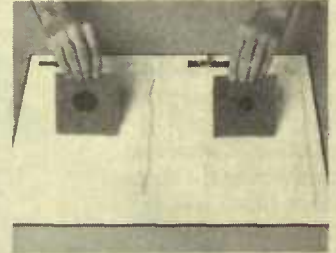
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## The extension of hospital liability: a landmark decision in the making<sup>1</sup>

Corinne Sklar

In caring for her comatose patient, a nurse detected a fruity odor on her patient's breath and alerted the physician. The diagnosis at this time of diabetes as the cause of the patient's coma came too late for the patient. In his decision the trial judge found that the damage caused to this patient was the result of the negligence of the internist, an endocrinologist; he also found that the hospital was legally liable for the negligence of this physician.

This decision is important because, in holding the hospital responsible, the trial judge extended the liability of Ontario public hospitals beyond previous limits: the physician in this case was not an employee paid by the hospital. He was a member of the medical staff and was an "independent contractor" billing patients either directly or, more commonly, through the provincial medical insurance plan. Previously, physicians in this position did not fall within the area of the hospital's legal responsibility for negligence. Instead, the physician was legally responsible to the patient directly. However, the patient and his family did not sue this physician as a separate defendant. Under the law as it stood until this decision of Mr. Justice Holland, the hospital would not have been liable for this negligence. If the limitation period for bringing a suit against the individual physician had expired, then the patient would have been unable to bring a law suit against this physician and receive financial redress from him.

The case is presently under appeal to the Ontario Court of Appeal and at this writing had not yet been heard. Because of the important ramifications of this trial decision for hospitals, it is likely that the final determination of this important legal decision will fall to the Supreme Court of Canada.

### Direct hospital responsibility

The liability of hospitals can arise either directly or vicariously, that is, through the act of another for whom the hospital is legally responsible. Direct responsibility may result where there is a failure of the hospital to fulfill its legal

obligations (duties) to the patient. Such failure may result from either a breach of contract or negligence (i.e. tort) or a combination of these. The duty or obligation to the patient results from the relationship between the hospital and the patient and damages may be awarded to the patient from the hospital where the hospital has failed to fulfill its undertaking to the patient. The direct responsibility of a hospital exists alone and is not contingent upon the nature of the relationship between the hospital and the person whose conduct resulted in the patient's harm. Hospitals are required to provide as part of their undertaking such services as nursing services, bed, laundry and dietary services, control of infection, reasonable facilities and equipment for diagnosis, investigation and treatment. The latter may vary from hospital to hospital depending on the scope and function of the facility.

Hospitals are legally required to exercise reasonable care in selecting competent staff members. For physicians, such responsibility is delegated to the medical Chief of Staff or the committee of physicians designated to perform this function. In Ontario, appointment to the hospital's medical staff is for one year at a time and may be renewed annually or the privilege may be revoked. The supervision of the medical staff is in the hands of such committees as well as part of the supervisory and "quality control" function. Physicians may be characterized as full time hospital employees under a contract of service, part time consultants, or "independent contractors" attached to the active medical staff roster; other variations of physician-hospital relationship may exist.

### Vicarious responsibility

Under the doctrine of "respondeat superior" (let the master answer), hospitals are vicariously liable for the conduct of their employees, servants and agents acting in the course of their employment. The primary element in fixing liability here is the nature of the relationship between the hospital and the employee (or individual whose conduct

is in question) and not the relationship of the hospital and the complainant. The view is that the master/employer by virtue of his position is able to control both the type of work performed and its manner of performance.

Originally, hospitals were not held responsible for the negligence of professionals in the performance of their professional responsibility; this liability has developed gradually over the past sixty years. In 1909,<sup>2</sup> the prevailing judicial view was that a hospital was only legally responsible to its patients for due care in the selection of competent personnel. The hospital was not considered legally responsible for the negligence of physicians and nurses acting professionally in the course of delivering patient care. Thus, a dichotomy developed whereby hospitals were legally vicariously responsible for negligence in the performance of "administrative" functions by professional employees such as nurses because such duties were part of the hospital's undertaking. However, there was no hospital responsibility if the task under consideration was performed in the exercise of "professional" skills because the master/hospital did not control the professional in such exercise.

Such a view could not be sustained as the role and function of the hospital in the community grew more complex and diverse and as increased social responsibility and accountability were imposed. Over the years, the "administrative" versus "professional" dichotomy was discarded and hospitals became vicariously liable for the negligent acts of their professional employees acting in the scope of their employment:<sup>3</sup> nurses, interns, residents, anesthetists, radiographers, etc.

However, within the expanding umbrella of hospital responsibility for its professional staff, some limiting aspects were retained — until *Yeapremian*. The distinction continued to be drawn between the relationship of a hospital with a professional on a "contract of services" and a "contract for services". The former attracted the hospital's responsibility because the relationship



was one of employment, ie. master and servant. The latter was excluded because the individual was an independent contractor and outside of the hospital's control of the work and manner of its performance.

In 1951,<sup>4</sup> the English Court of Appeal brought the "contract for services" into the ambit of hospital liability holding that where a physician is employed and paid by a hospital, whether under a contract of service or for service, the hospital will be liable for his negligence. Thus, the nature of the relationship between the hospital and the professional is also considered in the context of the remuneration of the professional — if the patient selects and pays the professional, then the hospital may not be responsible.

A Canadian decision illustrates this. In the case of *Aynsley v. Toronto General Hospital*,<sup>5</sup> the patient's brain damage was held to have been caused by the negligence of both the senior resident in anesthesiology and the privately employed anesthetist. The hospital was found responsible only for the negligence of the resident and therefore had to pay only for the percentage of fault apportioned to his conduct. The private anesthetist personally bore his apportioned cost of the negligence; he was directly legally responsible to the patient who had selected and employed him. The hospital was vicariously responsible for the negligence of the resident whom the hospital employed. The hospital was not responsible either directly or vicariously for the negligence of the private anesthetist. Similarly, a hospital is not responsible for the negligent acts of the private duty nurse who is selected and paid by the patient or his family. Hospitals are responsible for the negligence of their staff nurses in their delivery of patient care.

Very often today, a patient may be admitted to hospital under the care of a physician who is not a hospital employee and who has not been specifically selected by the patient. This was the situation in *Yepremian*, as we shall see below.

#### The facts

The patient, Tony, was a 19-year-old apprentice bodyshop repairman who lived at home with his family. On October 9, 1970, he returned home from work complaining of not feeling well. He was very weak and over the weekend his polydipsia and polyuria increased. The family took him to see Dr. G., the physician covering the practice of their family physician who was away that holiday weekend. A diagnosis of tonsillitis was made and erythromycin prescribed. The physician's notes presented in evidence did not mention the excessive thirst and urination of the patient. The patient was too drowsy and

ill to respond to questions. The family testified that the doctor had been informed of these symptoms.

That evening, October 12, Tony, who had continued to vomit and to drink and urinate excessively, began to hyperventilate. Alarmed, his family rushed him to Scarborough General Hospital emergency, where he was admitted in a semi-comatose state. The family testified that again Tony's symptoms had been reported. When asked about drugs (the hospital received many cases of young people with drug overdoses at that time), the staff were shown the medication prescribed earlier by Dr. G.

Dr. C. was the general practitioner on duty in emergency that night. The

"diagnosis" he recorded that night was the symptom "hyperventilation". Phenobarbital and valium were administered. Tony was already comatose.

Dr. R., the internist on call and a specialist in endocrinology, ordered Tony transferred to the I.C.U. in the early morning hours of October 13. No urinalysis was yet done. The case report contains a partial summary from the medical record of the treatment and observations.<sup>6</sup> The normal saline I.V. was changed to 5 per cent glucose at 4:00 a.m. and a foley catheter was inserted. The patient was comatose. His potassium level was recorded at 5.5 at 8:a.m., within normal limits. His vital signs during this period ranged as

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At 12:20 p.m. on October 13, the diagnosis of diabetes was made upon the nurse's report of her patient's fruity breath odor. A STAT urinalysis showed 4+ sugar. The I.V. containing soda bicarbonate was discontinued and insulin was given STAT.

The patient remained comatose or semi-comatose until he suffered a cardiac arrest about 12:55 a.m. on October 14. Severe permanent brain damage resulted.

#### Apportioning the responsibility

The trial judge considered the negligence and liability of the following:<sup>7</sup>

- Dr. G. (named as defendant)

• The nurses and laboratory staff (and hence the hospital under the vicarious responsibility doctrine)

- Dr. C.
- Dr. R.
- The hospital (for the negligence, if any, of Drs. C. and R.)

*Dr. G.* — Mr. Justice Holland found that Dr. G. had not met the standard of care required of the reasonable prudent medical practitioner and hence was negligent in failing to diagnose the diabetes of his patient. However, the cause of Tony's injuries was the cardiac arrest. Therefore, liability would be imposed on Dr. G. if his negligence caused or contributed to the cardiac arrest.

The judge found that the intervening acts of negligence "insulated" Dr. G. from liability. Dr. G.'s failure to diagnose the diabetes did not affect or contribute to the treatment Tony received at the hospital. He therefore dismissed the action against Dr. G.

*The nurses and hospital laboratory staff* — The trial judge found that there was no negligence attributable to these hospital employees for which the hospital could be held vicariously liable.

The laboratory staff was not responsible for the interval in processing of routinely ordered samples requested during the night shift. Such procedure was in accordance with accepted hospital standards.

It was suggested that the nurses should have initiated a STAT urinalysis on the patient's admission to I.C.U. Only a routine urinalysis was ordered. The trial judge found that the nurses complied with the prevailing hospital standards: such STAT orders were only done on doctor's orders. Hence, the hospital was relieved of vicarious liability here.

*Dr. C.* — The trial judge found that Dr. C. was negligent in his assessment and treatment of Tony. However, as with Dr. G., the intervening negligence of Dr. R. in the handling of Tony's case insulated Dr. C. from legal liability. Dr. R.'s negligence was not foreseeable and Dr. C.'s diagnosis did not contribute to Dr. R.'s subsequent conduct of the case.

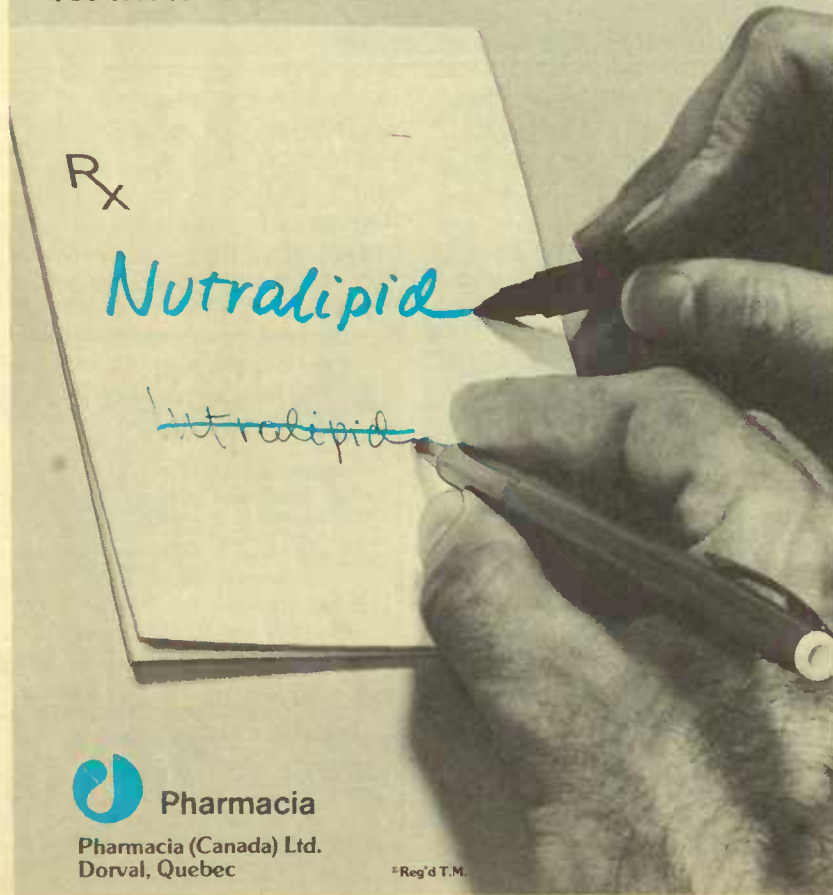
*Dr. R.* — Because Dr. R. was an internist and specialist in endocrinology, a specialty in which the care and treatment of diabetes falls, he was held to a higher standard of care than would have been expected of a general practitioner. The trial judge indicated that a serum potassium level below 3.5 creates a serious risk of cardiac arrhythmia leading to cardiac arrest.<sup>8</sup> The trial judge found Dr. R. negligent in failing to diagnose the diabetes earlier. He further found that Dr. R. ought to have been alert to the danger to Tony's serum potassium level in ordering sodium bicarbonate to deal with Tony's acidosis (which lowers potassium levels) and then ordering the insulin in response to the diagnosis of diabetes (insulin also lowers serum potassium). The record showed that Tony's potassium level was 5.4 at 8:45 a.m. and by 2:10 that day it had fallen to 1.5 and it remained below 3.5 thereafter. Potassium replacement was begun at about 3:30 p.m. that day. In the view of Mr. Justice Holland, Dr. R. failed to effect proper management of Tony's treatment once the diagnosis of diabetes was made, thereby resulting in the cardiac arrest.

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*"...It is my view that Dr. R.'s negligence in his treatment of Tony Yepremian was the cause of the cardiac arrest. If this young man had been properly treated after the diagnosis had been made, he would, in my opinion, have recovered without harm. I consider Dr. R.'s negligence to have been extreme and I have no doubt that he would have been held liable if sued."*<sup>9</sup>

*The hospital's liability for the negligence of Dr. C. and Dr. R. — Dr. R.'s negligence being the cause of the patient's damage, hospital liability for Dr. C.'s negligence was not considered. The trial judge stated that "The plaintiffs can sue whom they choose and I must be careful in deciding the issue of the liability of the hospital not to let myself be influenced by the result of the failure to sue Dr. R."*<sup>10</sup> (Note: If the hospital had not been found legally responsible here, and if the limitation period for bringing a suit against Dr. R. had expired, then there would have been no one legally responsible to compensate the plaintiffs for their loss. If Dr. R. had been a named defendant then the following alternatives might have resulted: (a) Dr. R. solely liable and the hospital freed of liability or (b) both the hospital and Dr. R. liable and hospital liability extended as ultimately occurred.)

Mr. Justice Holland, in finding the hospital legally responsible for the negligence of Dr. R., reviewed the relevant English, U.S. and Canadian case law and the relevant legislation. In his view, the following principles resulted, "except in exceptional circumstances:

1. a hospital is not responsible for negligence of a doctor not employed by the hospital when the doctor was personally retained by the patient;
2. a hospital is liable for the negligence of a doctor employed by the hospital;
3. where a doctor is not an employee of the hospital and is not personally retained by the patient, all of the circumstances must be considered in order to decide whether or not the hospital is under a non-delegable duty of care which imposes liability on the hospital."<sup>11</sup>

The instant case lies in the third category. The patient, his family, and the public-at-large, in the trial judge's view, looked to the hospital for a complete range of medical attention and treatment. The patient did not select the hospital and physicians in the usual manner. Here, the urgency of the situation dictated the "choice" of this hospital — it was the closest one. The decision refers to the expectation of the public: a high standard of care is anticipated from

all, and especially from the physicians, "skilled medical attention and treatment."<sup>12</sup> Similarly the admission to I.C.U. resulted in Tony's receiving care by the medical staffman on call at the time ("the luck of the draw" or rotation list).

The trial judge found that the hospital had selected Dr. R. as a member of the hospital's specialist staff.<sup>13</sup> The hospital had a legal responsibility to admit the patient and under *The Public Hospitals Act (Ontario)*,<sup>14</sup> the hospital is directly responsible to the patients therein for the quality of care delivered. In the view of Mr. Justice Holland, both *The Act* and common sense underscore this obligation of a hospital and the hospital has the opportunity of controlling the quality of medical service delivered.<sup>15</sup> The trial judge concluded that in accepting the patient, the hospital undertook to him a duty of care that could not be delegated.<sup>16</sup> He awarded damages assessed at \$390,262.11 and costs.

#### Implications

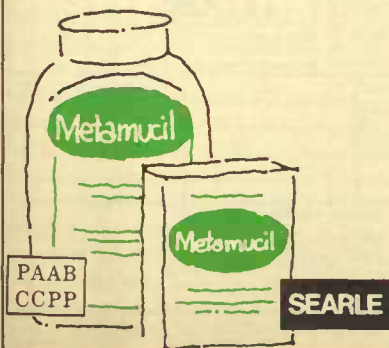
It is not clear from the decision whether the finding of hospital liability results from an extension of direct corporate responsibility or from vicarious responsibility. **What does emerge is the position that hospitals have greater accountability to the public for medical treatment.** (continued on page 48)

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# input

## Out of sight, out of mind

The October issue of CNJ, with its focus on maternal-child nursing, raised many important considerations.

One critical aspect of the potential crisis in OB nursing which was not addressed in the issue is the depressing fact that the maternity (postpartum, nursery and antepartum) area continues to be a repository for nurses who are, for any number of reasons, unable to function in other areas.

How often is the following statement included in an evaluation or transfer notice: "Ms. X has had considerable difficulty in carrying out the nursing process on this busy medical (surgical, orthopedic, neuro, etc.) unit. She would benefit from the opportunity to develop her nursing potential in an area with an easier (lighter, less hectic, i.e. lower status and priority) pace."

When Nurse X has shown her inability to function in any other area, she is sent to the OBS unit. (I suspect that geriatrics may suffer from the same problem.) Thus maternity units come to be staffed with an overabundance of nurses who "don't fit in" anywhere else and the talented and capable nurses in that area end up carrying the load.

Head Nurses, reluctant to play the role of hatchet women, do not document these less than satisfactory nurses out of the area, but rather attempt to carry on, thus lowering the overall standard of nursing care on their units.

We must look to education and inservice to develop the skills and knowledge necessary to improve the standard of nursing care in OBS nursing. We must also look at our image as a low status and low priority nursing area. As long as we are content to be the "dumping ground", it will be difficult to attract and keep

nurses who are able and anxious to keep pace with the many changes and challenges affecting OBS nursing.

—Frances M. Tufts, RN, BN, Don Mills, Ontario.

## Counseling today's teens

Author Shirley Wheatley (guest editorial, November 1979) suggests that "kids have the right to express their sexuality at any age". Is the role of the nurse to become that of social engineer for a society freed from morality and controlled by 'professionals'?

More contraception, more abortion, more sex education will not solve any problems. They haven't in Denmark, Sweden or Britain.

Self-appointed 'experts' have manipulated parents by using terms such as 'family life', 'values education' and 'responsible education' into thinking these courses will enhance responsible moral behavior. In fact, their basic philosophy is that there are no rights or wrongs, the family is dispensable and all lifestyles are equally valid. Parents who object are 'archaic oppressors'. Much of education is intended to encourage youth to discredit their parents and put them at the mercy of peer pressure in rap sessions manipulated by these biased 'professionals'.

People today have lost their concept of right and wrong; they are operating in moral confusion. This is tragic. It is even worse when these same people have a missionary zeal to impose their confusion on others — through legislation, schools and through the health services.

—John R. Caswell (student nurse) and Gay White Caswell, Saskatoon, Sask.

## Information please

I have heard that some hospitals in central Canada have day care facilities for children of their staff and I would like information regarding this.

Where I am employed we have a severe nursing shortage and I'm sure if there were a day care center more nurses with young families would be able to return to the work force, part-time or full-time.

For myself, the logistics of arranging care for a four-year-old and a 16-month-old so that I can work part-time are overwhelming.

Perhaps if I had something concrete to put to my hospital, I could get approval to set up a facility. I have even heard that they make money!

I look forward to hearing from colleagues.

—Gwendolynne Kavanagh, RN, S.S. No.2, Kamloops, B.C., V2C 6C3.

## Strength in numbers

One of my responsibilities as assistant director of nursing is the

Quality Assurance Program. I would like to form an Association of Quality Care Coordinators to promote educational and research programs in the area of quality assurance.

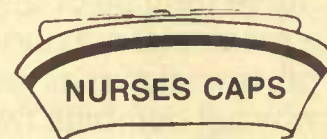
Could you publish this request in The Canadian Nurse? Interested respondents could write directly to me.

—Brian R. Rogers, RN, BSc., St. Joseph's General Hospital, North Bay, Ontario, PIB 3L9.

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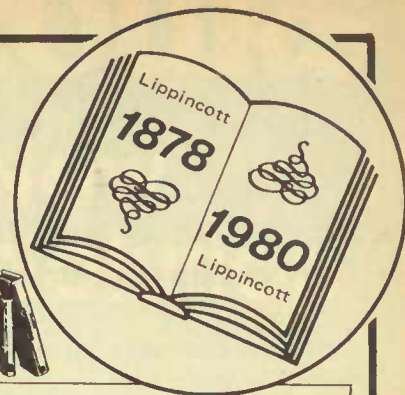
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Little, Brown. 313 Pages. Illustrated. 1979. \$15.50.

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# news

## Canadian nurses to write CGFNS exams to work in U.S.

The U.S. Immigration and Naturalization Service has announced that, contrary to earlier statements, Canadian nurses will *not* be exempted from the screening examinations all foreign nurses wishing to work in the U.S. must write.

The examinations, which are necessary in order to obtain an occupational preference visa (H-1), are given by the Commission on Graduates of Foreign Nursing Schools (CGFNS), established under the sponsorship of the American Nurses Association and the National League for Nursing. The April, 1980 exam will be the fourth such screening offered by CGFNS.

The day-long CGFNS exam tests the foreign nurses in nursing proficiency and English comprehension. Both sections of the test are in English. The nursing portion covers the same five subjects included in U.S. state licensing exams, namely, medical, obstetric, pediatric, psychiatric and surgical nursing. The CGFNS exam is not a substitute for the state board licensing exam. After passing the CGFNS test, applicants are required to take and pass the state licensing exam in the U.S.

According to Virginia Jarratt, RN, PhD, president of the CGFNS board of trustees, by determining nurses' ability to pass a state licensing exam before they come to the U.S., the CGFNS exam helps foreign nurses who are not fully prepared for professional practice in this country to avoid the disappointment, relocation costs and possible exploitation foreign nurses have experienced in the past. "The CGFNS screening procedure also helps assure the American public of minimum safe health care," Dr. Jarratt said.

Consideration will be given to exempting foreign nurse graduates, including those from Canada, who have already passed the state licensing examination (SBTPE) in one of the states of the U.S., from having to take the CGFNS exam.

The next CGFNS examination will be given April 2, 1980 in 28 cities outside the U.S. Exam sites in Canada will include Montreal, Toronto and Vancouver. Examination applications and Guidebooks for Applicants are available from CGFNS, 3624 Market Street, Philadelphia, PA. 19104, and from U.S. embassies and national nurses' associations in foreign countries. Filing deadline for the April exam was January 15, 1980. The next CGFNS exam will be held October 1st, 1980; filing deadline for this exam is July 14.

On the same day the April exam is given outside the U.S., it will be given in Los Angeles, Houston, Chicago, Miami and New York for foreign nurses who have not yet passed state licensing examinations in this country. Testing in the U.S. is an accommodation for foreign nurse graduates who are applying to the U.S. Immigration and Naturalization Service for an extension or a change in visa status. The exams in the U.S. will eliminate the need for these nurses, from Canada and other countries, to return to their homes to take the CGFNS exam.

## IV nurses exchange information, ideas

"Relationships are very important: nurses must take the time to speak to their patients...many nurses and doctors seem to be forgetting

this." Laura Legge, RN, Q.C. reminded intravenous nurses at the recent C.I.N.A. conference that although they may not be doing bedside nursing, they are very important and may be the only registered nurses that the patient sees. She emphasized that patients *do* matter as she commented on the increased incidence of legal suits involving hospitals, doctors and nurses.

The fourth annual convention of the Canadian Intravenous Nurses Association in Toronto last November brought more than 160 nurses together from across the country, including the Northwest Territories. With the objectives of facilitating idea exchange, upgrading knowledge and making available information on much of the new technology of IV therapy, the conference presented a group of highly qualified speakers and a varied selection of exhibits.

## Standards group

"CNA is taking an innovative and leadership role in the development of a definition and standards of nursing practice," says Pat Wallace, project director. Speaking on behalf of the group of seven (see *The Canadian Nurse*, October 1979), Wallace reported to CNA directors last Fall that the committee has adopted the principle that a conceptual model for nursing should be used to guide practice regardless of the setting in which that practice occurs. It wants this principle built into the definition and standards.

The Task Group has based its decision on a belief that the emphasis in nursing has shifted from a predominantly *dependent* role toward a more *independent* role, one that requires clarification in order to specify nursing's unique contribution to societal health needs. This uniqueness is

made explicit in any one of several conceptual models for nursing.

The development of Standards for Nursing Practice represents a beginning phase in an attempt to answer the question: "Does nursing make a difference?" The Task Group believes that standards must be tested and validated in practice settings to assure their usefulness.

Meetings will be held monthly from January through April 1980; the final report is expected to be completed for presentation to CNA's Board of Directors in June.

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We invite and welcome your comments, questions, suggestions or criticisms. Write: Pat Wallace, Project Director, The Canadian Nurses Association, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

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## Health happenings

On January 17th the first of a series of programs devoted to "demystifying health care" for the Canadian consumer was aired. Plans now call for the series, *The Medicine Show*, to consist of at least ten half-hour programs to be shown weekly, dealing magazine-style with a wide variety of topics related to medicine and health care in Canada.

Of special interest to nurses will be the program filmed in Winnipeg in which the host, author and broadcaster Ken Lefolli, interviews a group of nurses and asks for their frank opinion about the effectiveness of systems of health care delivery in Canada. Also planned is a program which deals with the image of the nurse as presented in contemporary popular literature, including Harlequin romances.

*The Medicine Show* is scheduled to be seen on major CBC stations Thursday evenings at 9:30, but local TV listings should be checked for time and availability. ♡



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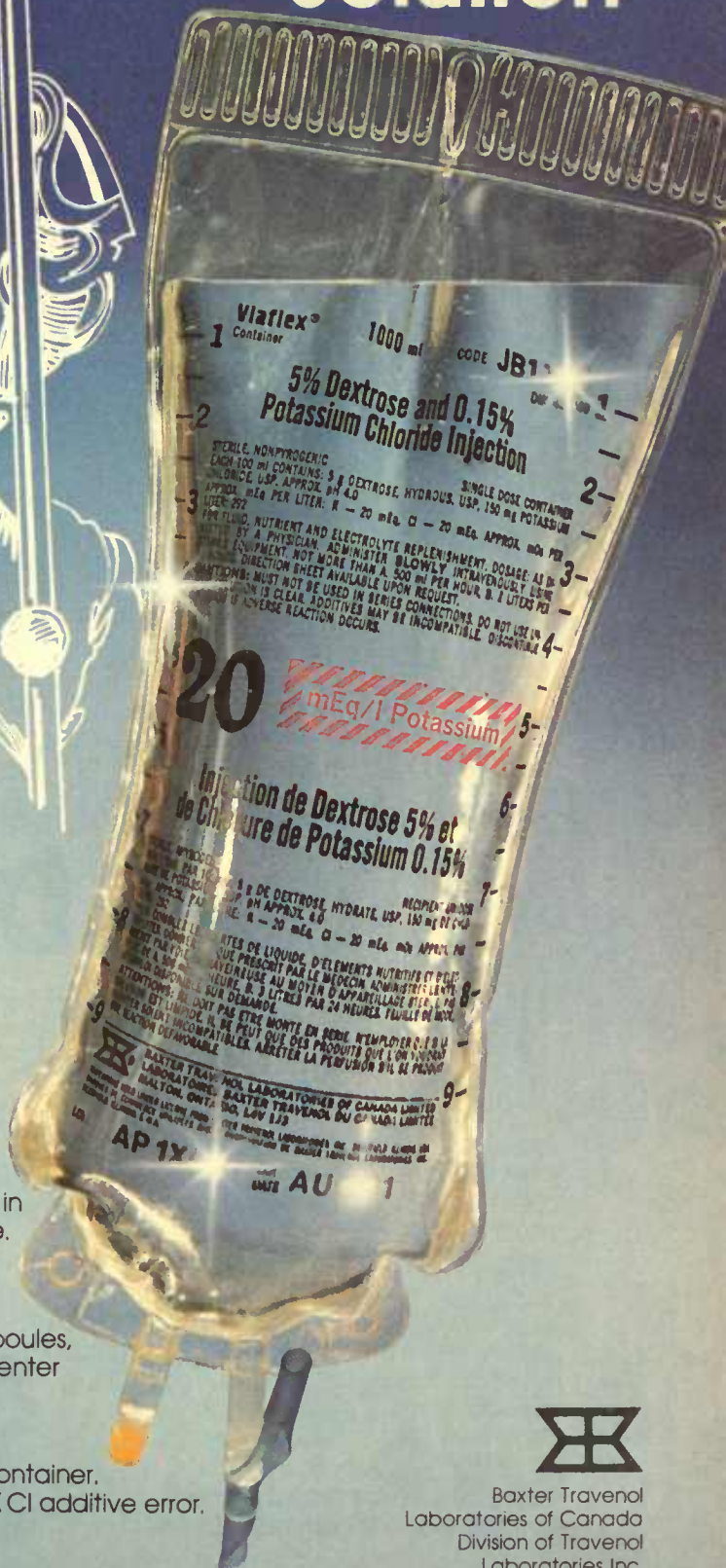
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# Successful Chemotherapy:

## quality care for the cancer patient

A complex relationship exists between the skilled and knowledgeable nurse and the well-informed patient receiving chemotherapy. Here's how a holistic approach can enhance your treatment plan and encourage patient compliance.

*Diana Law*

From diagnosis to death, cancer patients face one crisis after another in life: the initial diagnosis of a life-threatening illness, the discomfort of treatment, the unknown of a treatment regimen and possible recurrence of the disease followed by more treatment. Patient responses to any form of medical treatment are always both physiological and psychological; in cancer patients the latter effect is aggravated severely by the gravity of their disease and the continually investigative nature of their therapy. Disturbances in interpersonal relationships result along with physiological changes and psychosocial problems:

"equally as stressful as a confrontation with mortality are the other threats that cancer holds. Feelings of worthlessness due to the patient's feelings of unproductivity while ill, dependency, altered body image, role dysfunction, fears of alienation, social isolation and of stigmatization and anxiety over the physical symptoms such as pain, all may plague the patient concurrently."<sup>1</sup>

The nurse who is equipped with knowledge and skill can offer support to the patient on chemotherapy through a holistic approach to patient care. But, to accomplish this, you must look at and care for the patient as a whole person; his care cannot be 'atomized' into different parts.

Remember, chemotherapy *does* work: to the patient receiving the drugs they offer hope, and what you know about cancer and chemotherapy can be a determining factor in how the patient and his family adjust to the fearful circumstances of his illness and treatment regime.

People are more sophisticated in their awareness of medicine these days, and our patients now come to us fairly well-informed, and with questions that demand intelligent answers. The nurse who stays current with her skills and knowledge has a better understanding of the whole treatment process and this in turn gives her a degree of confidence and control which she can communicate to her patients.

### **Chemotherapy — how it works**

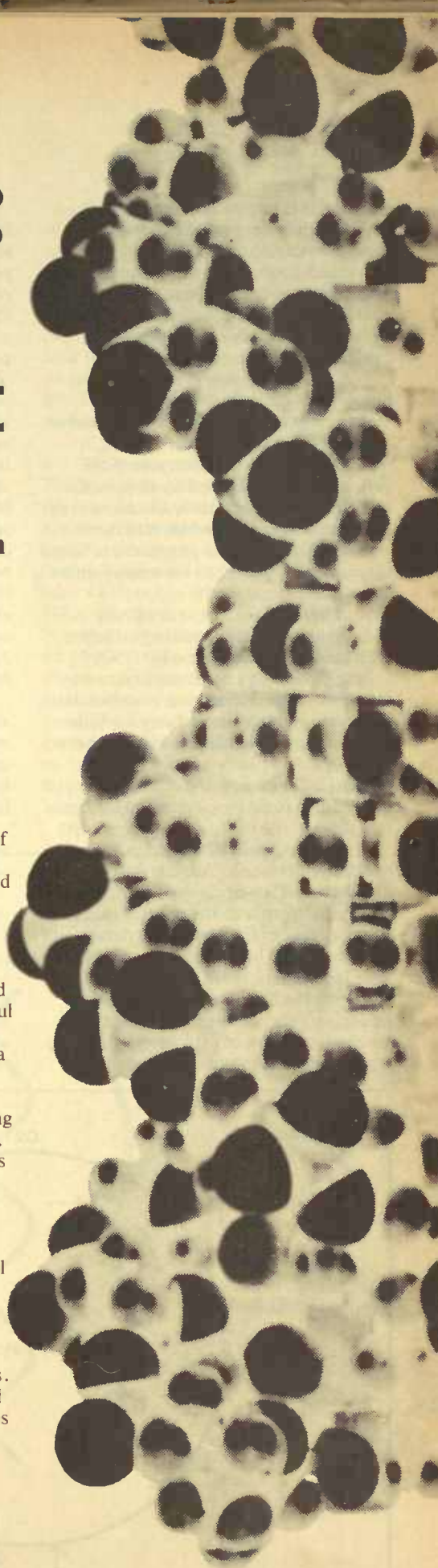
Cancer has been defined as uncontrolled proliferative cell growth which is harmful to normal physiological function. For example, in acute lymphocytic leukemia there is rapid proliferation of the lymphocyte stem cell line with a resultant rise in the number of circulating lymphocytes and decreased cell quality. Normal growth of other stem cell lines is greatly affected.

The basics of the cell cycle may be reviewed by means of a simple diagram (See Figure one).

GO — in this stage the cell is at rest until some internal mechanism triggers the cycle.

G1 — RNA and protein synthesis begin here.

S — in this phase DNA synthesis occurs. DNA is housed in the nucleus of the cell and contains all the genetic requirements for regulation of the vital cell processes such as growth, differentiation, specialization, etc.





**G2** — little is known about what goes on in this fairly quiet period except that some RNA synthesis occurs.

**M** — mitosis occurs at this stage; the cell divides into two "daughter" cells containing all genetic information. Each cell will now mature and repeat the cycle, or go into the **G0** stage.

A complete cycle is referred to as one generation time.

Cancer is a disease of the cell and so the chemotherapeutic agents work in different ways on the life cycle of the cell. Some drugs are cell-cycle specific — that is, they interfere with cell activity at a specific phase — while others are not. The drugs may be grouped into four categories according to their mechanism of action.

1) *Antimetabolites* These drugs are cell-cycle specific in that they interfere with metabolites essential for DNA synthesis. For example, methotrexate interferes with the enzyme dihydrofolate reductase, which is necessary for folic acid synthesis and subsequent synthesis of DNA.

2) *Antibiotics* Non-cell-cycle specific, these drugs react by binding to DNA at any stage of the cycle and interfere with the transcription of RNA and protein synthesis. Example: Adriamycin®.

3) *Alkaloids* Cell-cycle specific drugs which interfere with the mitotic spindle in cell division. Example: vincristine.

4) *Hormones* These drugs alter the cellular metabolism of the body by changing the hormonal milieu and making it unfavorable for tumor growth. Example: the use of estrogens in patients with cancer of the prostate gland.

Each drug dose kills some but not all the neoplastic cell population; the effect is more noticeable when a high percentage of cells are actively and rapidly dividing within a malignancy. The bone marrow and lymphoid components are good examples of highly proliferative tissues that are sensitive to chemotherapeutic agents. Nerve tissue, on the other hand, has a low percentage of cells dividing and is therefore less sensitive to these drugs. The goal of drug therapy is to destroy every abnormal cell, but the toxicity of the drug imposes limits on the dose that can be administered. Combinations of drugs are designed to maximize the therapeutic benefits of each drug in the combination, but to avoid overlapping toxicities; for example, vincristine causes little bone marrow depression as a side effect while Adriamycin causes significant bone marrow depression.

Unfortunately antineoplastic agents also attack normal cells. They will do most damage to highly proliferative cells and consequently their toxic effects are felt most keenly on the G.I. mucosa, hair follicles, bone marrow and skin.

To allow the normal tissues to repair themselves, drugs are given in cycles to provide drug free intervals.

#### A positive attitude

The patient receiving cancer chemotherapy does much better during treatment when he knows what to expect. Patients who are well-informed about their disease and its treatment, about the possible adverse effects and results, generally take appropriate action

on their own at the first sign of complications. The nurse's knowledge of drug toxicity, psychological trauma and the nursing care of both can play a major role in allaying much of the fear and anxiety brought on by the unknown.

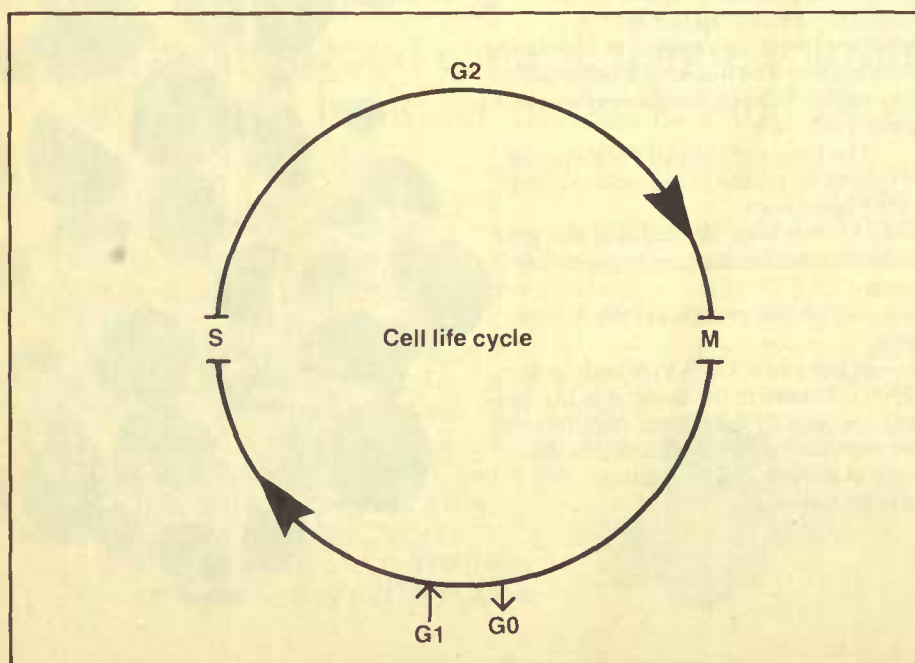
Both the nurse and the patient and his family need to know what can be done to prevent complications of treatment both in hospital and at home, and how to treat the unavoidable side effects. Both need to know the difference between a tolerable side effect and an acute toxic reaction.

A useful tool in patient teaching is the pamphlet or booklet used on a nursing unit which describes in clear language the basics of chemotherapy. Not meant to be a substitute for the nurse's presence in explanations, reading material can be an excellent facilitator to information assimilation if nurse and patient go over the material together.

It is important however to consider not only the negative aspects of cancer chemotherapy, but to help your patient develop as positive an attitude toward his therapy as possible. You can ensure that both he and his family are aware of the potential benefits as well as the risks. Chemotherapy requires a high degree of co-operation among all concerned, and patients and families should be partners with hospital staff in the care process.

At the outset, assess the patient's attitude and general level of anxiety. Listen to him, watch his body language and try to understand just how he perceives his disease and treatment plan. In this way you can gear your teaching plan to suit his individual level of tolerance and understanding, taking into consideration all the factors of culture, personality and psychosocial inter-relations.

Knowledge of his disease and treatment gives the cancer patient some measure of control over a potentially uncontrollable situation. Through participation in his own treatment and good teaching, nurses can strive to increase the degree of patient compliance. This is possible only if, as mentioned earlier, both the patient and his family are fully cognizant of chemotherapy and its implications.





Eighteen-year-old Alex, for example, who has a diagnosis of osteogenic sarcoma, returns to the hospital at regular intervals for his chemotherapy which involves high doses of methotrexate with citrovorum rescue. After each session of chemotherapy, Alex is discharged providing that his laboratory results are within normal limits, to complete his treatment cycle at home. This includes taking the oral citrovorum rescue drug on time every day, keeping himself adequately hydrated according to the protocol and testing urine pH. The latter is a good example of Alex's self-care; if his urine pH falls below 7, he takes an appropriate dose of soda bicarbonate to alkalinize his urine.

All patients benefit from a card or handout given at the time of discharge that outlines their responsibilities at home. Patient compliance is very important in chemotherapy, and successful treatment requires that all involved be well-educated, informed and responsible about the home phase of the treatment cycle.

#### Toxicity: how it affects the nurse and the patient

Here is a short review of the most common side effects of chemotherapy, along with the nursing actions that can be taken while the patient is in hospital and simple remedies the patient himself can use at home.

##### • *Leukopenia*

Leukopenia results from suppression of bone marrow function and is one of the most serious toxic effects of cancer chemotherapy. The white cell count is lowered, particularly the neutrophils that combat bacterial infection; thus susceptibility is increased and the patient may be infected by his own normal body flora.

Nursing actions include inspection of all body orifices for early signs of infection, and instruction to the patient on how to keep himself clean and avoid problems. Rectal abscesses and fistulas are common in leukopenic patients whose nutritional status is compromised. Temperature and the white cell count should be monitored closely; if the WBC falls below 1000/cu mm the patient may be put on reverse isolation.

Reverse isolation, obviously, is the reverse of usual hospital isolation — the goal is to protect the patient from outside infection sources. He may be put into a private room, and all persons entering the room will have to wear masks; gowns may be worn when direct contact is made and strict handwashing technique used.

Another area of concern with the leukopenic patient is the preparation of venipuncture sites; betadine solution followed by alcohol is used prior to puncture. The needle is secured in place with tape, but tape is *not* placed over the needle site itself; a sterile 2x2" gauze dressing with betadine ointment may be used and changed daily. The IV site should be changed every 48 hours if this is possible, to avoid infection. Any dermal abrasions sustained by the patient may be treated as for venipuncture.

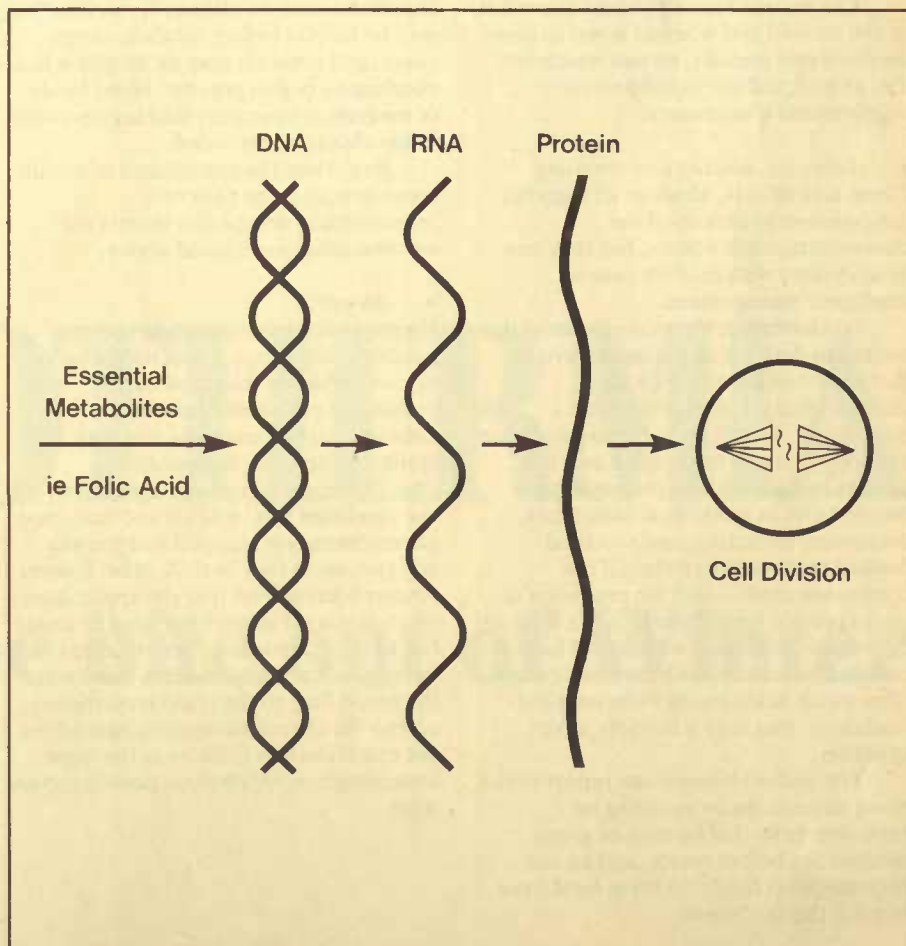
Not to be forgotten are the psychological repercussions of reverse isolation; the patient will need more support than ever to combat fear and loneliness and the anxieties that come from social isolation and increased dependence.

The patient himself can do a number of things to ameliorate leukopenia: he can keep himself clean and report any pain or discomfort such as on voiding etc. While in reverse isolation, he can use saline and hydrogen peroxide mouthwashes every three hours. These take the place of using a toothbrush which injures sensitive gum tissue. Mycostatin mouthwashes may be prescribed to prevent candida infection.

##### • *Thrombocytopenia*

This is also an effect of bone marrow depression, the principal sign of which is bleeding. In some patients, bleeding may occur at platelet counts of 50,000/cu mm (normal range is 140,000 to 400,000/cu mm) while not in others until counts are below 20,000.

Nursing actions include watching for obvious signs of bleeding, as well as observing for joint pain, petechiae, hematuria and headaches which may herald a bleed into the brain. Patients' rooms should be uncluttered to prevent accidental falls or bruises and IM injections and ASA should not be administered.





The patient himself can watch for and report any signs of bleeding such as nosebleeds or bruising. He can take care in his activities to avoid cuts or any kind of trauma; in addition he should know not to use a toothbrush to prevent gum bleeding, and not to use alcohol or ASA unless his doctor approves.

Thrombocytopenia can sometimes be temporarily improved with platelet transfusions, but often after a number of these transfusions patients develop antibodies and need to be premedicated with a drug such as Benadryl® prior to further transfusion.

- **Erythropenia**

This side effect of chemotherapy is yet another result of bone marrow depression evidenced by decreased red blood cell count and anemia.

Nursing actions include planning patient care to allow for frequent rest periods, and provision of adequate nutrition, especially foods high in iron. The nurse should watch for signs of anginal pain on exertion in patients who are otherwise already compromised — those who are elderly or who have infection.

The patient himself should know not to tire himself and when at home to plan frequent rest periods; he can watch his diet as well and use liquid protein supplements if necessary.

- **Anorexia, nausea and vomiting**

These side effects, alone or all together, are common to almost all the chemotherapeutic agents, but they can be alleviated with relative ease in intelligent management.

It is useful for the nurse to assist the patient to develop an eating pattern so that at certain times following chemotherapy and/or antiemetic medication, he will feel able to eat. Other apparently minor but helpful nursing actions include making the patient as comfortable as possible at mealtimes, presenting attractive meals — food cooked at home is excellent if not contraindicated — and the provision of liquid protein supplements in the form of egg-nogs or Sustacal® when solid food cannot be taken. Mouth care before and after meals helps too to overcome the 'bad taste' that may adversely affect appetite.

The patient himself can report to the nurse any nausea or vomiting he experiences so that he may be given antiemetics before meals, and he can encourage his family to bring food from home if this is allowed.

- **Diarrhea**

Patients receiving antibiotics and antimetabolite chemotherapy drugs are commonly afflicted with this side effect.

Nursing actions are aimed at treating the symptoms which can be accomplished by providing the patient with a low roughage diet high in foods that tend to constipate, such as cheese and boiled milk. Fluid loss must be replaced and good skin care is imperative if diarrhea is severe, antidiarrheals such as Lomotil® may be necessary.

The patient should be asked to report the incidence of diarrhea as soon as it starts to his nurse or doctor, and he can watch his diet and fluid intake.

- **Stomatitis**

Inflammation of the mucous membranes of the mouth often appears as a sign of toxicity from the antimetabolite and antibiotic drugs. Painful mouth ulcers make eating difficult and may progress to severe infections.

Good oral hygiene is an important nursing action using frequent mouthwashes of 1:1 saline hydrogen peroxide solution; these will improve taste and reduce bacteria. A topical anesthetic such as viscous Xylocaine® may be helpful before meals in severe cases, and antacids may be helpful when esophagitis is also present; bland foods of medium temperature and high protein fluids should be provided.

Reporting the appearance of mouth sores or pain is the patient's responsibility and he can initiate the mouthwashes mentioned above.

- **Alopecia**

Hair loss can be devastating to the patient's self-image, especially when it occurs suddenly. Hair follicles proliferate cells rapidly and are consequently damaged as much as malignant cells in chemotherapy.

The nurse can assure the patient that the condition is reversible and that once chemotherapy is stopped hair growth will resume in four to six weeks. Recent research has shown that the application of a tourniquet around the head or an ice bag to the scalp while chemotherapy is being given actually reduces hair loss; the blood flow to the scalp is restricted and so the chemotherapeutic agent does not reach the hair follicles in the same concentration. Of obvious benefit too are wigs.

The patient, once informed by nursing and medical staff that alopecia may occur, can prepare his family and friends for the change in his appearance.

These are only the most common of the side effects of chemotherapeutic agents; several others exist — effects on the reproductive system for instance — and nurses should be aware both of the actual effects and of how to help the patient alleviate them.

### **Creative caring**

The patient with cancer who is undergoing chemotherapy is a tremendous challenge to a nurse; besides continuously updating her basic knowledge of drugs, their actions and interactions, she must draw on her personal talents and resources, plus those in the community around her, to foster a positive and hopeful attitude in her patient. How both nurse and patient perceive and accept the disease of cancer and its treatment have a profound effect on the success of chemotherapy. ❖

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**Diana C. Law, RN, BScN**, is a graduate of the Toronto General Hospital School of Nursing and has completed a post-graduate course in psychiatric nursing as well as her baccalaureate degree which she obtained from the University of Alberta. She is presently working as the medical nursing co-ordinator at the Foothills Hospital in Calgary where, she writes, "we are developing staff and patient teaching programs related to oncology."





Photo courtesy of Health and Welfare Canada

# HYPOTHERMIA

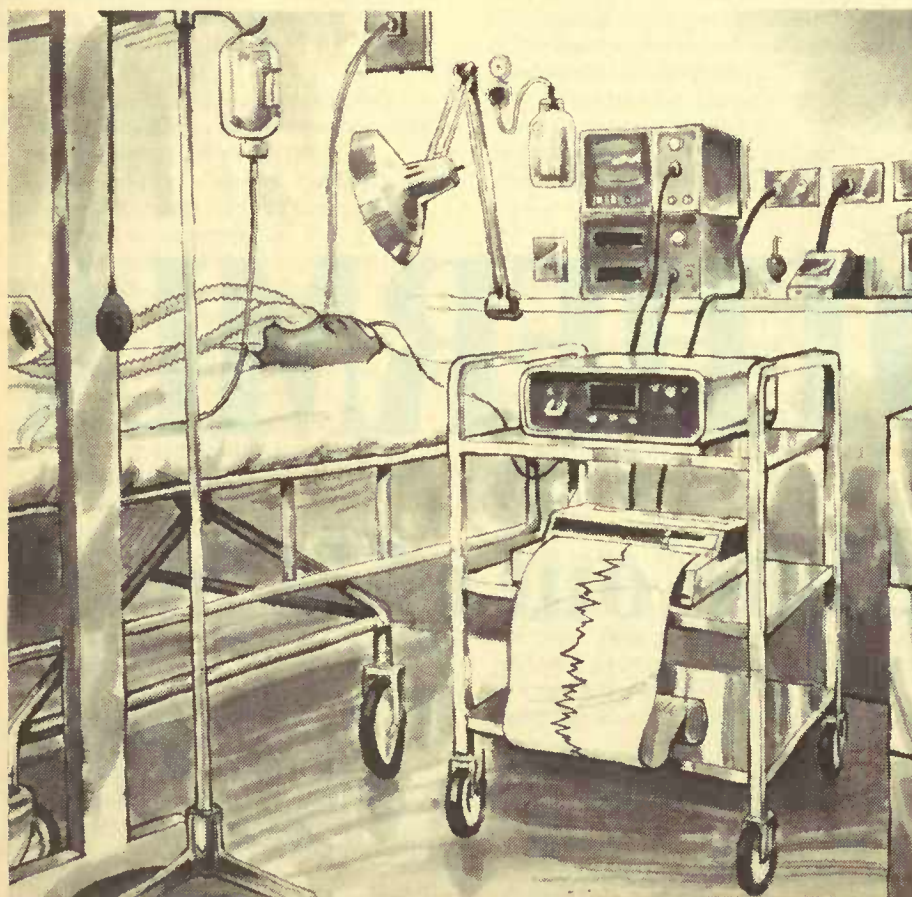
## Taking the bite out of Winter



# Controlled Hypothermia:

## A treatment for an acute Anoxic Incident

Stephanie and her six-year-old playmate, Marc, were fascinated by the spring thaw. Playing on the brink of the river, poking with sticks at pieces of floating ice and throwing rocks into the murky water, they were feeling the freedom of spring. Suddenly, Stephanie lost her footing and fell into the icy water. Marc, terrified by her screams, ran for help. Ten minutes later, Stephanie was pulled from the water, not breathing and without a pulse. Cardiopulmonary resuscitation was initiated by a rescuing policeman while bystanders waited for an ambulance. What followed for Stephanie's parents and the medical staff that cared for her were ten days of anxious waiting — ten days of not knowing what the results of their treatment and the eventual outcome would be.



Margot Thomas

### Controlled hypothermia

The treatment of choice for a victim of accidental hypothermia and acute anoxic episode is controlled hypothermia and barbiturate induced coma until cerebral edema is resolved.

Controlled hypothermia, the external regulation of body temperature to below 33.3°C, is used in medicine for several purposes:

- to lower excessively high fevers of febrile disease entities, including drug and anesthetic reactions, such as malignant hyperthermia
- to reduce oxygen consumption and control bleeding intraoperatively, such as in cardiac surgery
- to reduce cerebral edema secondary to metabolic or mechanical injuries of the brain.

Use of hypothermia results in a reduction of basal metabolism, decreased respiratory rate, pulse, blood pressure, hormonal response and cellular oxygen requirements. As hypothermia tends to reduce cerebral blood flow, the fluid shift from intravascular to intracellular areas is decreased and the nervous tissue need for oxygen is reduced. For these reasons, controlled hypothermia is frequently used in conjunction with other supportive measures in the care of patients with cerebral edema secondary to brain injury.

### Barbiturate induced coma

Continuous coma produced purposefully by hourly infusions of barbiturates, usually thiopental sodium (Pentothal® Sodium), pentobarbital sodium or phenobarbital (dosage of 1-5 mg/kg/hr) has been shown to reduce intracranial pressure (ICP) in patients having increased ICP due to cerebral edema.<sup>1</sup> Although the exact mechanism that reduces the intracranial pressure is not well understood, a reduction of cellular cerebral metabolism and cerebral blood flow have been identified as important aspects of the process.

Barbiturate induced coma renders the patient without cerebral function (no reflexes or spontaneous movement) and can produce a temporary flat (isoelectric) electroencephalogram (EEG) and fixed, dilated pupils. This treatment is used in conjunction with intracranial pressure monitoring, mechanical ventilation, anticerebral edema medication and frequently hypothermia until the critical period for cerebral edema has passed. At that time barbiturates are discontinued and while the ICP is carefully monitored the patient is "allowed to wake up".

Drawing by Alan King, The Citizen, Ottawa



### Monitoring intracranial pressure

Intracranial pressure is the cumulative force exerted within the skull by the brain, cerebral blood flow and cerebrospinal fluid (CSF). This pressure is readily affected by any change in volume of any of these three elements, as the fixed and rigid nature of the cranium does not allow compensation for variations. Any increase in these volumes results in an increase in ICP, commonly seen with space occupying lesions, intracranial hemorrhage, build up of CSF secondary to a blockage of the skull drainage system and cerebral edema.

Cerebral edema is the pathologic shift of water and sodium from surrounding blood vessels into brain cells in response to brain injury either mechanical (closed head injury) or metabolic (acute anoxic incident). The edema fluid is rich in proteins which have leaked through the capillaries into the cells and thereby cause an osmotic pull of more fluid into the intracellular and interstitial fluid spaces.

With increased ICP, cerebral function is threatened. If the ICP is not adequately controlled, severe brain damage can result. With new monitoring devices that place a small probe in the CSF surrounding the brain, ICP can be measured directly. The indirect signs of ICP — level of consciousness, size and reaction of pupils to light, vital signs and motor response — are essential in evaluating neurologic status but are not usually evident until some pathologic change has occurred to the brain. ICP monitoring is a useful adjunct in the care of patients with head trauma, pre and post operative craniotomies, intracranial hemorrhage and disease processes characterized by cerebral edema.

Measured in the same scale as arterial blood pressure to allow for comparisons, normal ICP ranges from 4-15 mm/Hg<sup>2</sup>. Elevations of ICP can be treated with medications such as Mannitol and Dexamethasone; with barbiturate induced coma, hypothermia, hyperventilation and in some cases neurosurgery (skull decompression and CSF drainage).

### Stephanie's story

Stephanie, aged five and one-half years, was brought to the Emergency Room of a nearby general hospital by ambulance after submersion in a very cold freshwater river for ten minutes. Mouth to mouth resuscitation and cardiac massage were started at the scene and continued until the child was intubated and ventilated in the E.R. and heart function had returned to sinus bradycardia with a rate of 46 per minute.

On arrival at the E.R., Stephanie was described as being apneic and asystolic, with pupils fixed and dilated. Rectal temperature on admission was 26°C. Following initial resuscitation and stabilization, large loading doses of intravenous Pentothal® Sodium were given and a paracentesis involving instillation of warmed saline into her abdomen was performed in an attempt to raise her body temperature above the critical level of 30°C. Below this temperature, cardiac arrhythmias and ventricular fibrillation which are difficult to reverse are common.

At the local children's hospital, to which she was transferred, Stephanie was taken immediately to the ICU and placed on a hypo/hyperthermia blanket and under an overbed heater as the attempt continued to raise her core temperature to 30°C. She was ventilated with 100 per cent oxygen initially and PEEP (Positive End Expiratory Pressure) was used to reduce pulmonary edema. PEEP maintains inflation of all areas and segments of the lungs. By maintaining positive pressure in the alveoli on expiration, the normal transudation of fluid across the alveolar capillary membrane is retarded.

Stephanie was attached to cardiac and respiratory monitors, vital and neurological signs were watched closely and a foley catheter and naso-gastric tube were inserted. On admission, fulminant pulmonary edema was treated with stat doses of intravenous furosemide (Lasix®). She was then taken to the neurosurgical operating room where an intracranial pressure probe was inserted. As the probe was covered with an occlusive dressing, the only nursing care of this closed system involved accurate readings and awareness of implications of changes.

Stephanie's care, day-to-day condition, her ongoing medications and treatments during her stay in ICU are all illustrated on the accompanying chart.

The barbiturate induced coma which had been initiated at the general hospital E.R. was maintained with hourly injections of Pentothal® 150 mgm intravenously which were reduced to 40 mgm/hr. Decadron®, a long-acting synthetic adrenocorticoid, was administered routinely as its intense anti-inflammatory activity is especially effective in reducing cerebral edema. Ampicillin therapy was also begun at this time.

Controlled hypothermia was initiated once Stephanie's temperature had been raised to 32°C and until day four her temperature was regulated between 30 and 32°C.

With the use of hypothermia and barbiturate induced coma, Stephanie's blood pressure was very low and unstable. To determine that there were no other causes of her labile status, tests indicated on the chart were completed regularly with a special focus on serum Pentothal® levels. Any measurement outside of the desired 2.5-5 mgm per cent range resulted in adjustment of the hourly infusion dosage. By day three, the unstable blood pressure recordings coupled with a low hematocrit resulted in the infusion of packed cells. Even though the cause of this persistent blood pressure problem was probably the treatment regime, Stephanie's management could not be continued without further infusions of fresh frozen plasma and then albumin.

On day four, a gradual and slow rewarming process was initiated. Over 24 hours, Stephanie's temperature was increased to the normal range, although she did require external regulation of body temperature until day six. As cerebral function returned, the brain could then regulate body temperature without external assistance. Concurrent with rewarming, the Pentothal® infusions were discontinued. Consequently, pupillary response to light returned fully within 24 hours. Note that with rewarming and the discontinuing of barbiturates, the effects of hypothermia were reduced, that is, the apical pulse and blood pressure increased and the intracranial pressure rose slightly. The following day, day five, spontaneous respirations were noted and by day seven, Stephanie was opening her eyes to command, withdrawing limbs to painful stimulation and breathing at a rate of 30-36 per minute. Complete recovery from the effects of the barbiturate induced coma and hypothermia was evident on day eight when Stephanie was extubated and she started to speak.

During this period, Stephanie's general care involved all of the normal aspects of nursing care of the unconscious, mechanically ventilated patient, including eye, mouth and skin care, passive exercises, etc. Chest physiotherapy was initiated only on day four as active chest physio is sometimes contraindicated for the individual with an unstable ICP. At this time physio was given every two hours to minimize the severe problem of atelectasis that had developed despite the use of PEEP.



	Admission	Day one	Day two	Day three	Day four
<b>Body °C temperature</b>	Initially 26° warmed to 32°	Controlled Hypothermia 30—32°	30—32°	30.5—31°	30.5° then warmed to 37° over 24 hours
<b>Vital signs</b>					
<b>Apex</b>	48—70	68—80	60—80	52—64	56—90 After warming
<b>Blood pressure (Systolic)</b>	50—60	60—80	60—80	70—80	60—90 After warming
	Respirations mechanically ventilated at 21/minute	Mechanically ventilated at 15/minute	Mechanically ventilated at 12/minute	Mechanically ventilated at 12/minute	Mechanically ventilated at 12/minute
<b>Neurologic signs</b>					
<b>Pupils</b>	Fixed and dilated				Fixed at 0700 hrs
<b>Eye opening</b>	None				Reacting sluggishly at 1200
<b>Verbal response</b>	None				Reacting moderately at 2200
<b>Motor response</b>	None				
<b>ICP (mm Hg)</b>					
Normal (5—15 mm Hg)	1—3	1—5	2—5	1—5	2—8
<b>Medications</b>	Pentothal® 150 mgm IV Q1H Decadron® 6 mgm IV Q6H Ampicillin 1 Gm IV Q6H	Pentothal® reduced to 40 mgm Q1H Decadron® reduced to 3 mgm Q8H		Dilantin® 30 mgm IV Q8H	Pentothal® discontinued at 0700 hrs  Cloxacillin 475 mgm IV Q6H
<b>Stat Medications</b>	Lasix® 20 mgm IV			Dilantin® 100 mgm IV	Lasix® 20 mgm IV
<b>Tests</b>	Arterial Blood Cases* CBC*, Platelets, Bun*, Electrolytes* Calcium*, Creatine Serum and Urine* Osmolarity	Chest X-Ray° EEG ECG Serum Pentothal Levels (desired levels 2.5-5 mgm%)	EEG ECG Tracheal Aspirate for C & S	Cross and type EEG	Serum Pentothal Levels
<b>Notes</b>	*Done daily and more frequently during days 1—5 as needed	°Done daily for days 1—8		Packed cell infusion of 200 cc	Fresh frozen plasma infusion of 150 cc Physiotherapy (chest) Q2H

Stephanie's labile blood pressure precluded prolonged turning and change of position, so fastidious skin care every two hours was necessary to protect her from problems arising from pressure or cold to her poorly nourished skin.

#### A happy ending

The demands of the technical management of a case such as Stephanie's are outweighed only by the psycho-emotional demands. For seven days Stephanie's prognosis was very guarded, no one could predict whether or not she would be extremely brain

damaged as a result of her severe anoxic accident. Both medical and nursing staff were working in an apparent void: feedback to their treatment course was non-existent. Of course, this was most difficult for Stephanie's parents. They could never be given much reassurance; all we could say was that her condition was unchanged and would remain that way until the treatment was over. Even by day 10, after active treatment had been discontinued and Stephanie was reacting fairly normally, the possibility of residual brain damage was not completely ruled out.

Now, a year later, Stephanie is at home, a full-time grade one student, with no apparent disabilities. Her EEG, respiratory function and cardiac status are all normal. Her only regular follow-up is with a local psychiatric clinic which is looking at some minor problems with "acting out". It would seem that the root of her problem is more likely to be a reaction to her instant "stardom" in the community than an organic manifestation. ♡



Day five	Day six	Day seven	Day eight	Day nine	Day ten
36.5—37°	36.5—37.3°	36.5—37° Maintained without hypothermia blanket	36.5—37.5°	37° (oral)	36.7—37°
86—100 80—90 Mechanically ventilated at 13/minute spontaneous resp. noted	80—100 86—100 Spontaneous respiration with ventilator at a rate of 20/minute	86—100 90—100 36—Spontaneous respirations with mechanical ventilation	70—100 90—100 24—34 Not ventilated		
Equal and reacting briskly to light	Attempting  Crying Spontaneous movement gag and cough reflex present	To command  Withdrawal to pain	To command  Mouthing words Hand grips strong toe pushes strong	Talking Alert and oriented to person and place	Playing and reading books "Want to go home"
3—10	0—10	5—13	2—11	ICP Probe Removed	
	Decadron® decreased to 2 mgm IV Q8H		Decadron® decreased to 1 mgm IV		
asix® 20 mgm IV					
EG			Tracheal aspirate for C and S		
erum Pentothal levels					
Albumin infusion of 40 cc	Hypothermia blanket turned off		Extubated	Nasogastric tube removed Foley catheter removed Physio decreased to Q4H Up out of bed	Transferred to floor!

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\*Unable to verify in CNA Library

**Margot (Brown) Thomas**, a graduate of the Faculty of Nursing, University of Toronto, was part of the team who cared for Stephanie (the pseudonym chosen for the little girl in her article). Margot has worked in the

*Surgical Intensive Care Unit of the Montreal General Hospital and is presently on staff in the Intensive Care Unit of the Children's Hospital of Eastern Ontario.*

Stephanie's seven-year-old companion who went for help has since received a \$100 award presented annually to a person who has made a special contribution to the community and the policeman who dove into the frigid waters and rescued Stephanie will receive the Ontario Medal for Police Bravery, his fourth bravery award for this incident. He was quoted by a local newspaper as saying "My biggest award was saving her life."



# Accidental Hypothermia:

## Emergency Rewarming Techniques

Donna Rae

**The correlation between a society, its physical environment and the type of high risk activities its members engage in often affects the type of emergency treatments that must be perfected. In Canada, as our society becomes increasingly fitness oriented, outdoor activities in the most inclement conditions frequently result in accidental hypothermia.**

As an acute life-threatening emergency, accidental hypothermia requires immediate and active therapy. Although the ethical nature of inducing hypothermia for experimental reasons has restricted the amount of and quality of research that has been documented, the statistics that are available along with the relevant case histories, have helped to identify reasonable approaches to emergency treatment.

Accidental hypothermia occurs when the body's core temperature falls to less than 35°C (95°F) as a result of exposure to cold. Immersion in water or prolonged exposure to cold weather may result in this hypothermic state. Infants with poor thermoregulatory mechanisms and elderly people whose lower basal metabolic rates are coupled with debilitating disorders are particularly susceptible.

### Pathophysiology

Bodily response to cold involves several reactions.

- **Heat Conservation:** Reflex responses which are activated by cold are controlled by the posterior hypothalamus and either increase heat production or decrease heat loss. Shivering, hunger, increased voluntary activity and increased secretion of norepinephrine and epinephrine are all mechanisms which increase heat production; while cutaneous vasoconstriction, curling up and horripilation (goose flesh) decrease heat loss.

Shivering, an involuntary response to cold and fear, is mediated by the shivering center in the posterior hypothalamus. As skeletal muscle tone increases throughout the body, the individual begins to tremble when a high level of muscle tension is reached. These

tremors may vary from slight quivering to violent contractions which result in an increase in muscle cell metabolism and a consequent elevation of heat production.

The catecholamine hormones, norepinephrine and epinephrine, released primarily from the adrenal medulla as a response to any stressor including cold, increase the force and rate of contraction of the heart. Norepinephrine produces vasoconstriction in peripheral vessels while epinephrine released into the circulation increases the rate of cellular metabolism. As basal metabolism increases with decreased temperature,

the need for oxygen consumption increases and the cardinal sign of increased respiratory rate becomes apparent.

Horripilation, goose flesh, raises the hairs on the skin thereby providing pockets of insulation. This is an effective means of conserving heat in lower animals who have an abundance of hair, however, the effectiveness of this response in man would seem to be of little consequence.

Despite compensatory mechanisms, prolonged exposure to cold results in heat loss, lowered core temperature, declining metabolic rate, reduced shivering and muscle rigidity.

- **Circulatory System:** Initially with the response of increased metabolic rate and sympathetic activity, an increase in



Photo courtesy of Health and Welfare Canada



respiratory minute volume, heart rate and cardiac output is evident. Continued exposure to cold, however, results in depression of the medullary respiratory center, cardiac pacemaker activity and conduction, causing decreased respiratory rate, heart rate and cardiac output which may lead to hypotension. When core body temperature falls below 32°C, the ensuing myocardial irritability may induce arrhythmias or heart block. In fact, "Once cardiac temperature falls to about 31°C, the cardiac output declines. At about 25°C, it often becomes insufficient to meet even the reduced requirements of the body tissues for oxygen and with further cooling the heart may stop completely."<sup>1</sup>

Hypothermic victims are at high risk to develop ventricular fibrillation and cardiac dysrhythmias due to a decrease in oxygen supply to the cardiac muscles. As the body temperature drops, it becomes more difficult for oxygen to be released from hemoglobin resulting in a reduction in oxygen available for cell use.<sup>2</sup> The consequent irritability of the heart places the patient at risk to cardiac standstill.

- **Nervous System:** Below 32°C a progressive depression of the central nervous system including altered mental state, depressed reflexes and advancing coma may be noted as hypothermia is prolonged.

- **Renal Responses:** As hypothermia develops, renal arterioles constrict and cardiac output decreases causing a decline in renal blood flow, glomerular filtration rate and finally, oliguria. As renal tubular function is depressed, the transport mechanisms are impaired resulting in deviant regulation of volume and concentration of fluids, acids, bases and waste products such as creatine, creatinine and uric acid.

- **Acidosis:** Carbon dioxide, not effectively exhaled as a result of decreased respiratory minute volume and tissue hypoxia, which predisposes anaerobic metabolism, result in acidosis, both respiratory and metabolic.

#### Assessment and treatment

In an emergency situation such as this, assessment and treatment must be established according to priorities.

1) **Airway:** Utilizing the A(airway), B(breathing), C(circulation) guidelines for determining priorities, a patent airway and respiratory adequacy must be assessed and treated first. Movement of air may be evaluated by observing the patient for respiratory effort and movement of chest or upper abdomen.

When dubious air exchange is assessed, treat the patient by tilting the head back as far as possible by placing one hand under the neck while placing the other hand on the forehead. Forward displacement of the lower jaw in addition to head tilt may be required to extend the neck and lift the tongue away from the back of the throat. If movement of air is not established by these methods it is necessary to utilize mouth to mouth resuscitation or aids such as airways, ambu bags or endotracheal equipment.

2) **Circulation:** In the event of cardiac standstill, external cardiac massage may be given. It has been suggested that massage be "at about half the normal rate",<sup>3</sup> that is, eight compressions to two ventilations every twelve seconds in a one man resuscitation. This reduced cardiac massage rate is indicated by several factors. First, as blood volume decreases, a longer period of time is required to allow adequate filling of the heart chambers. As well, as cell metabolism slows, less oxygen is required at the cell level and the inevitable cardiac irritability prevalent in these states may be aggravated by aggressive cardiac massage and arrhythmias may ensue.

3) **General Baseline Data:** Data for the hypothermia victim should include vital signs using deep body temperature, level of consciousness, shivering response and urinary output. Information from laboratory analysis and electrocardiograms may also be required. The goals of this monitoring are to detect early warning signals; to establish any reason for deterioration and to evaluate response to treatment. All data should be recorded immediately upon admission and monitored frequently during recovery.

4) **Temperature:** Deep core body temperature may be obtained rectally or at the tympanic membrane. A normal clinical mercury thermometer is of limited use as temperatures below 35°C are not recorded and deep rectal insertion is not possible. Electronic probes such as the "Electronic Thermometer Modes 43TA, Yellow Spring Instrument Company, scale range 20°C (68°F) to 42°C (100°F)," facilitate the recording of lower temperatures at the tympanic membrane. Accurate data is provided, but specialized equipment is required and skilled personnel must be available to place the probe against the tympanic membrane and seal off the auditory meatus.

Continual temperature data collection is essential as often there is an "after drop" of the body core temperature when cold blood from the periphery reaches central areas.

5) **Blood Pressure:** Frequent monitoring and recording of blood pressure will detect early warning signals of "rewarming shock". Cardiac output is reduced with hypothermia and as peripheral vessels dilate with rewarming, blood pressure may drop further.<sup>4</sup>

6) **Shivering Response:** Shivering base line data upon admission of hypothermic victims will vary according to the body's core temperature and cause of hypothermia. Victims of immersion hypothermia tend to exhibit less shivering than victims of slow exposure hypothermia due to their rapid loss of body heat and subsequent loss of consciousness.

When shivering thermogenesis is used as the method of rewarming for these victims, ongoing monitoring of the shivering response should be recorded. Some non-shivers require treatment in warm whirlpool baths when shivering thermogenesis does not appear to be adequately affecting the "after drop" in temperature.<sup>5</sup>

7) **History:** Upon admission, obtain a history from family, friends or observers, as treatment management will depend on any existing chronic or debilitating disorders as well as the cause of the hypothermia. Victims of slow exposure hypothermia more frequently present with mood changes which may range from confusion to a state of profound aggression. These persons are also predisposed to hypovolemia due to fluid shifts.

#### Rewarming techniques

Treatment for hypothermia consists of rewarming. Three main techniques are now being used.

**Central Body Rewarming** by means of peritoneal dialysis, hemodialysis or cardiopulmonary by-pass. Internal body warming reduces the possibilities of cardiac arrhythmias and ventricular fibrillation, a prime consideration as "a heart below 28°C can rarely be defibrillated by drug therapy and/or electric shock...although the heart does seem to have an increased tolerance for prolonged fibrillation when hypothermia exists..."<sup>6</sup>

The primary advantage of this technique is that the warmth, with resultant vasodilation of vessels, reaches the primary organs of the body first. This is of major consequence to the heart as it attempts to restore a normal cardiac output. The heart's own cell metabolism increases and thereby generates its own increased oxygen demands. However, the complexity of core rewarming requires constant health team expertise and the risk of infection is a constant threat.



**Active Surface Rewarming** through baths or heating pads. Warm baths raise body temperature by convection, which is the transference of heat by means of currents in liquids. Therefore if the bath water can be circulated with compressed air the effectiveness of the bath is increased. Vasoconstriction is relieved in peripheral vessels and venous return to the heart is increased by means of this application of exogenous heat. However the sudden return of cold blood to the body core areas may precipitate an "after drop" in core body temperature, which can potentiate the possibility of ventricular fibrillation, due to further cooling of the myocardium. Excessive peripheral vasodilation may be reduced if extremities, that is arms and legs, are initially kept out of the warm bath.

This is a very efficient method to raise skin temperature. By reducing shivering and decreasing cell metabolism, the cellular demand for oxygen is minimized. Using this technique, body temperature is raised much more quickly than with core temperature rewarming. Water temperature should be maintained between 40-44°C and treatment terminated when forehead sweat is noted.

**Passive Surface Rewarming**, whereby body temperature is restored through shivering thermogenesis. Spontaneous rewarming or warming by endogenous means is simple and can be established in or out of an institutional setting. Shivering, one of the body's mechanisms to increase heat production, in combination with insulation by blankets to decrease heat loss causes less trauma to the patient who is susceptible to complications such as arrhythmias.

Spontaneous rewarming is slow and for this reason this technique is not always the method of choice for treating the hypothermic patient who is hypoxic and at risk, but for the elderly and enfeebled patient who has slowly become hypothermic passive rewarming is recommended. "...In a patient with a stable rhythm, whether bradycardia or atrial fibrillation, stable vital signs, and 'near' normal blood gases, passive, peripheral rewarming during monitoring can be successful..."<sup>7</sup>

Victims of accidental hypothermia may simulate death. Nurses should always remember, however, that there have been many reports of successful revivals after one hour of active rewarming and supportive care. Death should not be a diagnosis unless there is a failure to revive after one hour of resuscitation and rewarming to 30°C. ♣

## Clinical Features of the Accidental Hypothermia Patient

### Moderate Hypothermia (Most frequent)

cold skin  
hypopnea  
cyanosis  
bradycardia  
irregular pulse  
hypotension  
poorly reactive dilated pupils  
polyuria or oliguria  
shivering  
muscle rigidity  
altered mental state  
edema

### Profound Hypothermia\* (Rare)

cold skin  
apnea  
cyanosis  
cardiac standstill  
pulseless  
unresponsive  
fixed dilated pupils  
no urine output

\*Profound clinical features are indistinguishable from death, therefore, death may be defined if there is failure to revive after one hour of attempted resuscitation and core body temperature has been raised to 30°C.

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*Janet strikes out for a long run on a sunny March afternoon. The wind is at her back and Spring is in the air. On her return trip, however, the sky has clouded over, the wind is in her face and her clothes are wet with perspiration. She is shivering with the cold and wonders if she can make it home...*

*Out for a day's cross country ski expedition, your companion, who is constantly dieting, begins to complain that she is tired and cold, that she wishes she had eaten breakfast or brought a snack. By now, you are ten miles from your car...*

*Whether you ski, jog, climb, paddle a canoe or just enjoy a peaceful walk in the outdoors, you should be aware of hypothermia. Knowing how to prevent and treat both hypothermia and frostbite makes living in our northern climate safer. In fact, it COULD save your life.*

Judith Banning

Since hypothermia strikes quickly and is potentially lethal, prevention is obviously better than cure. Whether the cause is *cold* (not necessarily extreme cold, since problems usually occur between 0 ° and 10 °C) *wetness* (including fog, melting snow, immersion or perspiration) or *wind*, the typical victim is exhausted and unprepared to protect himself. Hypothermia may be a threat in Spring, Summer or Fall, not just Winter, so persons engaging in outdoor activities should always be prepared for changing weather conditions and be realistic about their personal ability to cope with the environment.

Prevention begins with recognition of the subtleness of cold:

- Never overestimate your strength or ability or that of your companions.
- Dress for changing temperatures, wind and wet by wearing peelable layers which include underwear that breathes, does not absorb moisture and produces an insulating layer of warm air; a wool layer and a windproof well-ventilated jacket.
- Always carry an extra garment and wear a hat.
- Remember to carry liquids and food, especially carbohydrates and stop for nourishment frequently, as food is a vital source of heat. If you feel fatigued, stop and rest.

## How NOT to be a victim

The first signs of hypothermia usually include shivering and slow or slurred speech; you may recognize it in yourself, perhaps by noticing instances of sloppy grammar. Loss of memory and confusion may also be noted; some victims become very obstinate and insist that the right direction to take is really the opposite to the obviously correct one. Often at this point, the individual cannot be dissuaded. Babbling and euphoria are eventually followed by stumbling and loss of agility, then muscle rigidity, loss of alertness and eventually unconsciousness. As soon as initial signs are recognized, efforts must be made to prevent further heat loss and then to rewarm the victim. The key is to start treatment early before coordination and judgment are impaired.



In an area protected from the wind, remove all wet clothing and replace with dry. Insulate the individual from the ground as much as possible using branches, space blankets, sleeping bags, etc. The most efficient method of rewarming on the trail is to place the victim nude in a sleeping bag with one or two rescuers, also nude. A hypothermia victim alone in a cold sleeping bag will not generate enough heat to rewarm himself. If no sleeping bag is available, external heat may be generated by the rescuers huddling around the victim. Isometric exercises are invaluable at this time as little energy is expended and activity is maintained.

If the victim is conscious, warm liquids and foods high in carbohydrates are indicated. However, alcohol should never be consumed before or during activities in cold or variable weather conditions as it causes peripheral vasodilation, resulting in cooling of greater quantities of blood.

When hypothermia is recognized, treatment must be initiated immediately and on the spot. Attempting to move a hypothermic victim to a treatment area, if there is a chance that the hypothermia will progress, is usually futile and may end in tragedy.

**Immersion hypothermia**, occurs much more quickly and leaves little time for intervention. If you find yourself a victim of immersion in cold water, do not remove any layers of clothing; they will provide insulation. Assess the distance to shore before deciding to swim: studies have shown that an individual will cool much faster swimming than floating motionless. The University of Victoria, in studying immersion hypothermia, reports a 1 °C drop in temperature for every quarter mile the victim swims.

Since your priorities are to remain afloat and to reduce heat loss from chest and groin areas, treading water is your most efficient lifesaving technique. If you have a personal flotation device, hold your arms tight to the sides of the chest and your knees tight together, then draw your legs up towards your abdomen, thus rolling yourself into a ball.

When assisting with the rescue of a victim of immersion hypothermia, follow the steps outlined above: that is, remove wet clothing (if have no dry clothing available, wring out wet and reapply especially if wool) and prevent further cooling. Since in this instance, the temperature drops more quickly, chances of caring for a victim with a temperature as low as 30 °C or lower are great. In these cases cardiac instability must be respected. Jostling when moving or undressing must be avoided; at this stage arrhythmias and ventricular fibrillation cause most of the fatalities. Even if the victim is conscious, he must remain inactive for 20 minutes to one hour after rewarming is initiated, since after a rescue core temperature may drop up to three degrees Centigrade with the "after drop" phenomenon. This movement of cold blood from the extremities to the core and the excitable myocardium is increased with any activity.

All submersion victims, even if conscious and alert should be admitted to an observation unit, as statistics show 15 per cent of near drowning victims who are conscious at the time of hospital admission die of "delayed" drowning from pulmonary and cerebral causes.

## Frostbite

Usually, frostbite is restricted to the extremities of the body, including hands, feet, nose and ears, and exposed areas such as cheeks and chin. Sudden cessation of cold or discomfort from a sensitive area and perhaps a feeling of warmth, often indicate the beginnings of frostbite. Treatment is determined by the depth of tissue affected.

**Superficial frostbite** which involves only the skin and the tissues immediately below, is recognized by sudden blanching and then a white waxy appearance. Usually the area will appear frosty and frozen on the exterior but gentle pressure will reveal softness and resilience of the tissues below. This type of frostbite can be treated immediately by rewarming; apply steady pressure (no rubbing) with a warm hand, tuck frostbitten fingers into your axilla, or remove boots and socks and rewarm toes and heels by placing them on the abdomen of a companion, meanwhile protecting them from the wind.

With rewarming, the area will become numb, mottled blue or purple and then will begin to swell, sting and burn. In more severe cases, blisters will appear in one to two days and will turn black as they dry over the next two weeks. Aching and burning may persist for several weeks and once swelling disappears, the skin will peel.

**Deep frostbite** involves the skin, subcutaneous tissue and often extends deep into the tissue to include the bone. In these cases, the injured part is hard and solid and cannot be depressed.

Severe cases of frostbite should not be rewarmed on the trail. A strong individual can walk a great distance without inflicting further injury to a frozen foot, but once a frozen part is rewarmed, refreezing may occur very quickly. Weight therefore should never be placed on the rewarmed part and an individual whose frozen feet or toes are rewarmed on the trail is

automatically reduced to a "litter case" — a situation which may create a crisis for the remainder of the group.

If a fracture or severe sprain occurs in extreme cold, the extremity beyond the fracture is susceptible to frostbite, especially if traction is applied. Immobilize the fracture with a well padded splint, remove shoes or boots from the foot below the injury and wrap loosely in warm dry clothing.

To rewarm an area with deep frostbite, remove all clothing from the affected part and place in warm water (no warmer than 44 °C) or wrap in towels and pour warm water constantly over the area. Pain will increase to a fairly high level by the end of the rewarming process; this will be worse in individuals suffering from circulatory problems. If no water is available, rewarm with warm air, wrap loosely in warm blankets or use contact with warm human flesh (abdomen or axilla). Never rewarm by exercising, as this will increase the extent of the injury. Never rub the injured area at any point during the process or afterwards. Never rub the frozen area with snow or thaw it in cold water, and finally, discourage smoking or consumption of alcohol.

After rewarming huge blisters will develop over the next three to seven days and the injured area will be blue-violet or grey in color. Aching, throbbing and shooting pains begin about day two and persist for two to eight weeks. Mobility of the affected joints is further hampered by swelling of the entire extremity; this swelling may last up to one month.

In these cases, prevention of infection becomes a priority. No pressure should be exerted on the rewarmed area; expose the area as long as it is warm or wrap in loose, soft, dry dressings. Do not prick or break blisters. Passive physiotherapy is



contraindicated as the depth of injury is usually difficult to assess. However, the individual should be encouraged to move the affected part when possible; a whirlpool bath (37 °C) is sometimes helpful. Initially the injured area should be kept horizontal with the body, changes in elevation may be increased with recovery.

#### Prevention

If you want to avoid frostbite, keep in mind the following tips:

- always dress properly for outdoor activity
- ensure an adequate intake of food for heat production
- avoid tight-fitting clothing
- avoid dampness (wet feet, perspiration, etc.)
- wear mitts instead of gloves
- be careful when loading cameras or handling metal objects
- carry extra socks, mitts, etc. and wear two pairs of socks
- be aware of windchill factors
- do not smoke or consume alcohol outdoors
- remember that previously frostbitten areas are extra sensitive and subject to the cold. ❖

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## Hypothermia and the senior citizen

**Fact or fancy:** *If you or your patient is over 65, you are more susceptible to hypothermia than a younger person. (Answer: Fact)*

For many years, public health nurses in Britain have been aware of this problem and have taken steps to overcome it. Now, community health nurses in Canada are faced with caseloads that include a disproportionate number of elderly individuals subsisting on fixed incomes, who have adopted a sedentary lifestyle, eat poorly, dress inadequately and, for the most part, spend their time in quarters that are not properly heated.

As nurses we are programmed to look for elevations in temperature; all too frequently we ignore the implications of lower temperature readings. Naturally the implications of hypothermia are magnified when paired with disease entities such as diabetes or heart trouble or with drugs such as anti-psychotics which may potentiate hypothermia. It is all too easy, for example, for an elderly person to slip on a bit of ice when he/she steps outside to get the mail or to forget to close a door or a window.

What can we do? As nurses we must be aware of the signs of hypothermia and act to identify persons-at-risk. We can suggest increased layers of clothing, encourage daily exercise, ensure that adequate food is available and that the individual is actually eating.

Remember, a lower thermostat setting means an extra sweater for most of us. For the elderly it can spell danger, even death.





# You're in hospital with what?

Maureen Steen

**Psoriasis.** It means different things to different people: to the stand-up comedian it is cause for reference to the 'heartbreak of psoriasis', but to the anguished and depressed hospitalized psoriasis patient, it means loss of self-esteem, loss of self-confidence — maybe even the loss of his job.

This year I found myself between these two extremes, hospitalized for three weeks' treatment of widespread psoriasis. The all-too-familiar red itchy patches, plaque and endless scales had been with me for years, but this year was different. After an almost total clearing of my skin in the summer, a sudden flare-up did not respond to the usual corticosteroid treatment. My thighs, anal area and scalp were covered with thick hard scales, and the guttae, or drop-like lesions, covered the rest of me except for my face.

I was, in short, a mess. My dermatologist suggested hospitalization for the standard treatment which I knew was messy, uncomfortable and time-consuming. How could I get away? My job as a public health nurse had become particularly demanding since I had taken on the role of team leader; the university course I was taking was a real 'heavy' one, and my busy household of husband, three teenagers and a dog could not do without me for three weeks.

Thanks, I said, but no thanks.

The Christmas that followed was definitely not merry; shopping, baking and mid-term exams left me drained. After the holidays I saw my physician who prescribed an antidepressant. This was both good news and bad news — my mood elevated, my skin worsened. A drug reaction is spotted a good deal sooner in someone with clear skin. By the time I stopped taking the antidepressant I had good reason to be depressed — I was a swollen, uncomfortable, itchy mass of psoriasis. More tests showed that the fatigue and nausea were not due to nerves, but to a problem with liver function.

I was scared. I would go into hospital I decided, but I was told it was too late...all the dermatology beds were full.

I waited two months for a bed and in the meantime dropped my university course, and cut my family and social obligations to a minimum. I still worked — my reasoning was that I would just feel sorry for myself at home waiting, and my doctors agreed — but I was performing at less than my usual standard.



**10:00 A.M.** — First anointing with "the goop". This stuff is incredible. My room smells like railroad ties and I look like a coal miner. It stains, it smells, but it works! Special potions and lotions went on scalp and peri-anal areas because tars are contraindicated in these areas where they may burn the skin.

**12:30 P.M.** — Lunch.

**2:00 P.M.** — Reannoint with "goop". It is amazing how much of this stuff wears off. Because of this, sheets are not changed daily for the psoriasis patient. You sleep in your blackened, greasy, scaly envelope for a week. This not only saves laundry but every time you get into bed more tar is rubbed in.

**3:00 P.M.** — Nap.

**4-6:00 P.M.** — Read, listen to radio or contemplate black, greasy navel.

**6:00 P.M.** — Supper.

**7:00 P.M.** — Visitors — "Don't touch me — it stains!"

**9-10:00 P.M.** — Last tar ointment of the day. I put on my ointments myself but the nurses "do" me where I cannot reach. Believe me, touch as a therapy should not be underestimated.

Finally, the call came to go to hospital, and I learned I was to go on the Goekerman regime.<sup>1</sup> This treatment was first used at the Mayo clinic 50 years ago and is a conservative but messy treatment of psoriasis. Basically, it involves the use of coal tar ointments, coal tar baths and exposure to ultraviolet light. The tars are antipruritic and antimetabolic, but most of all they act to increase the photosensitivity of the skin so that the ultraviolet light can reach and alter the affected cells.

My routine in hospital was as follows:

**7:00 A.M.** — Bath in special tar solution and shampoo with tar.

**8:00 A.M.** — Breakfast.

**9:00 A.M.** — Physiotherapy for ultraviolet treatment. Stripped, I was baked for increasing periods of time, like a chicken on a barbecue — now front, sides, back.



## PSORIASIS — the disease

Psoriasis is a chronic recurring skin disease that manifests as papulosquamous lesions; primary lesions form as papules, and the remainder are covered in scales.<sup>3</sup>

Approximately one to three per cent of the general population is affected by psoriasis, but reporting is inaccurate because minor cases often do not seek treatment. Psoriasis occurs more frequently in colder climates, and in the winter months.

The cause is unknown. What happens is that the DNA in the skin cells is somehow programmed to increase the speed of the cell cycle so that mitosis, or proliferation of cells, occurs much more rapidly than usual. The buildup of cells results in the extra skin or scales that appear. Koebnerization is the process by which guttae-type psoriasis seems to spread; an abnormal skin reaction appears in areas of previously normal skin.

## TREATMENT

The purpose is to alter the cell cycle to slow proliferation; treatment may be systemic or topical.

### Topical

- Steroids<sup>6</sup> — mild: 1% HCl  
— medium: Synalar, Betnovate  
— strong: Lidex, Halog
- Anthralin
- Tars: coal tar ointment\*, Estarjel
- Ultraviolet light alone
- UV light with tar (Goekerman regime)
- UV light with Anthralin (Ingram regime)

### Systemic

- steroids
- Methotrexate<sup>7</sup> — this drug is a folic acid antagonist which reduces the amount of DNA available to epidermal cells; because it inhibits cell growth it is commonly used to treat malignancies, and is a powerful immunosuppressant. The drug has many side effects (see CPS) especially impaired liver function, and is used only in patients with severe psoriasis who are being monitored.
- PUVA<sup>8</sup> — Psoralen taken in conjunction with UV light treatments. Methoxsalen, a photosensitizer, is taken two hours before light therapy, and helps to disrupt DNA replication. Side effects include premature aging of the skin and ocular problems.

\*It should be noted that in animal studies, coal tar skin treatments have been found to be carcinogenic; in human use however, the benefits gained by tar treatments for psoriasis patients are thought to outweigh the risk of skin cancer.<sup>9</sup>

When one's 'body image' is such that one is repulsed by his or her own appearance, acceptance by another is wonderful. There is little time for nurses on any busy medical floor to stop and chat, but I did appreciate the few times anyone did.

Amazingly, I could see and feel real progress; the slight sunburn from the light was uncomfortable but never actually painful.

There are many misconceptions about psoriasis; even some of my colleagues were skeptical about the length of my treatment, although, on the whole, I found the hospital staff very understanding. The most serious misconception is that psoriasis is caused by 'nerves'. In a study done by Drs. Sobel and Baughtom,<sup>2</sup> the role of stress and emotional factors was demonstrated to be not a casual one; however, the real question that arose was, which comes first, the disease or the stress? Yet another study of some 5600 psoriasis patients examined over a period of ten years failed to identify a particular psoriasis personality type.<sup>3</sup>

This is not to say that the severity of psoriasis does not vary with life stresses, but that stress is only one of several factors that serve to trigger the disease process. Others include infections, trauma, and drug reactions.

Day care facilities for psoriasis treatments are becoming increasingly popular. Various methods have been employed but some medical researchers emphasize the importance of group therapy as part of the overall treatment.<sup>4</sup>

Psoriasis remains an enigma — chronic, persistent and resistant to treatment. Research has failed to discover what causes psoriasis although heredity seems to be important; while new pharmaceuticals and new methods of treatment are being developed psoriasis patients just have to learn to live with their affliction. For the nurse, it is important to be aware of the deep psychological effects of this disease, especially for teenage patients. A little acceptance, support and understanding can go a long way.

For myself, my hospital stay has given me a reprieve, a temporary 'cure'; I know that I have but to live one itch-free day at a time. ♡

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# Day care:

## the selective alternative for psoriasis patients

Margaret Burns

R.K. Schachter

The Psoriasis Education and Research Centre located in Toronto is a unique facility in Canada. It was developed expressly for the purpose of education, research and the treatment of patients with psoriasis. Affiliated with the Women's College Hospital and the University of Toronto, under the direction of Dr. R.K. Schachter, the center is staffed by a nurse-coordinator, 2 RNA's, a secretary, a medical photographer and research personnel as well as a staff dermatologist.

The center (PERC) is a day hospital which operates from Monday to Friday in two 'shifts': 0800 to 1600 hours, and 1300 to 2100 hours. This arrangement allows patients to continue with their regular work, family and social patterns as much as possible. The center has been able to treat the average patient for approximately one-third of the cost of inpatient hospitalization.



Along with the program of active treatment, the staff at PERC has organized a three-part education program for patients.

### Treatment

Any patient who attends the center must be referred by a dermatologist or family doctor; everyone referred is assessed initially by the staff dermatologist and a decision is made about treatment at that time. There are two types of psoriasis that cannot be treated in a day hospital—erythroderma and generalized pustular psoriasis.



The patients' treatment regimen is for three weeks' duration and they may attend either the morning or the afternoon session, whichever is most convenient for them.

A typical routine includes: tar bath, tar shampoo, ultraviolet light, application of medications and an education session. After a lunch break, medications are re-applied, followed by a relaxation hour and then removal of medication, tar bath and tar shampoo.



During the three weeks, the patients are seen regularly by the dermatologist who assesses their progress and looks after any treatment problems.



### Education

A unique facet of PERC is the individualized education program, the goal of which is to help patients learn about psoriasis, self-care and means of coping with stress. In a large center like Toronto, our patients come from a wide range of backgrounds, and we try to tailor each patient's program to his or her individual requirements.





To do this, the nurses use a detailed history and interview form to aid in assessing the patients' knowledge of the condition, and how well each person has been coping with his diagnosis. By analyzing the information, it is possible to outline each patient's specific educational needs. Basically the program consists of discussion in several areas.



The pathophysiology of psoriasis is explained, along with factors that may aggravate the condition, and an overview of present-day therapy. A pharmacist gives a session on both the prescription and proprietary (over-the-counter) drugs that are used in psoriasis treatment, discussing drug action and possible side effects. Instruction is given regarding proper use of the drugs most commonly used.

A yoga class is held weekly to provide patients with a means to relax.



A dermatologist conducts an informal question and answer session, which gives the patients an opportunity to ask a doctor any questions about psoriasis that may occur to them during their treatment. Small informal groups are organized periodically throughout the treatment schedule, led by the nurses, which aim to increase the patients' independence and ability to care for themselves at home. Good general health promotion is stressed, and community resources available to the patients are discussed, along with any subjects that may come up.



A physiotherapy session demonstrates exercises that can be used as part of a program for good general health, and an occupational therapist sees patients individually about lifestyle activities.

An important part of the group sessions is discussion of the role stress plays in each individual's home, work and social life, and patients are encouraged to discuss openly the problems they encounter because of their psoriasis. Commonly discussed is the sense of frustration many patients feel as well as embarrassment, due in part to the fact that the general public has been poorly educated about this chronic skin disease.

Family members are included in the educational sessions and they are shown how to apply the medications.



#### Research

The nurses at PERC assist in the ongoing research by aiding in the collection of data and participating in the clinical trials evaluating effectiveness of new drugs and modes of treatment. Research meetings are held regularly to discuss research and the plans for future projects.



#### More than skin deep

Work at the Psoriasis Centre is very satisfying and rewarding for the nursing staff; looking after patients' physical and emotional needs is a very challenging experience. When patients are admitted we see how low their self-esteem is, and how they need support and encouragement. It is our job to gain their confidence in three short weeks and to watch them as their outlook on life and their self-image changes, for the better. ♡

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# A RACE AGAINST TIME: caring for a patient with RADIATION ENTERITIS

How do nurses cope with a patient who just gets worse in spite of everything that's done? A group of nurses in Moose Factory found they had no choice but to organize themselves to give the best possible care to their patient, to give as much of themselves as possible, and to hope.

*Roberta Ronayne*

Nursing in a small northern Ontario hospital means caring for Cree Indian and Inuit patients whose culture, lifestyle and language are foreign to nurses educated in southern Canada. Because of the distance from large urban centers, most of the medical and nursing staff is generally in Moose Factory on a short term basis, but this does not prevent the formation of close bonds between staff and patients, resulting in a greater understanding of the culture of northern peoples. Such was the case with Mrs. K.

Mrs. K., a 56-year-old Cree Indian, was admitted to hospital in the Fall with a diagnosis of abdominal pain and pneumonia. She appeared pale, thin, and in considerable discomfort, finding difficulty even in walking.

We knew from previous admissions to our surgical unit that Mrs. K. had been an insulin-controlled diabetic for 20 years, that she had a history of congestive heart failure and vascular insufficiency which had resulted in a below-the-knee amputation, and that she had received a full course of radiation more than two years ago for Stage II carcinoma of the cervix.

Just prior to admission, Mrs. K. had been living at home caring for her family and her aged ill mother; she had been in a great deal of pain, receiving analgesia parenterally on visits from her physician, while her condition worsened.

At first, we assumed Mrs. K. was a terminally ill cancer patient and prepared to support her towards a peaceful and dignified death, but this was not to be the case. Mrs. K.'s symptoms, which included a low grade fever, elevated WBC, nausea, vomiting and abdominal pain, necessitated a small bowel x-ray series which revealed a bowel obstruction requiring surgical treatment.



Photo courtesy of Health and Welfare Canada

## **SURGICAL PROCEDURE NO. ONE**

During Mrs. K.'s first surgical procedure 2 1/2 feet of small bowel were removed because of an obstruction due to the effects of radiation enteritis: adhesions between the omentum and the bowel as well as necrosis were found at the junction of the ileum and jejunum. The remainder of the bowel showed some effects of radiation, along with an inflamed peritoneum and a distended gallbladder. There was, however, no evidence of pelvic metastasis.

Following major surgery, Mrs. K. required intensive nursing care. We organized our priorities into the following headings:

- nutrition and fluid balance
- relief of pain
- psychological support
- infection control.

## *Nutritional fluid balance*

When Mrs. K. had first been admitted to hospital she was on a regular diet, able to choose foods she liked to eat; her diabetes was controlled by daily injections of Lente insulin.

Post-operatively, Mrs. K. was on intravenous therapy with naso-gastric drainage and her Lente insulin was discontinued, replaced by p.r.n. doses of Regular insulin, to be given according to doctor's orders after urine testing.

Monitoring Mrs. K.'s electrolyte balance was a medical priority, and unfortunately at this time, our laboratory machinery was malfunctioning. Blood samples for chemistry had to be sent to another hospital on a regularly-scheduled airplane flight, and the results were phoned back to us the same day. Although inconvenient, this was effective until our equipment was repaired.



Based on the electrolyte results, the doctors ordered potassium supplements for Mrs. K.'s I.V. solutions; she did not do well however, and developed post-operative diarrhea (due to prolonged antibiotic therapy), nausea and vomiting. The doctors treated her with anti-emetics, but Mrs. K. lost weight rapidly, until she had lost a total of 16.2 kg in five weeks.

#### *Pain relief*

Mrs. K. had been living with pain for a long time, but after surgery her need for analgesia increased. The nurses were alert to non-verbal signs of the need for medication in the patient's behavior such as rubbing her abdomen and guarding, as well as more obvious signs such as moaning. As the need for relief of pain increased further, recognizing the patient's need became less of a problem than locating sites for injection. Mrs. K. was already receiving anti-emetics intramuscularly, and injections of insulin subcutaneously, and with her muscle wasting and peripheral vascular disease, the choice of sites was limited. There was the question too of the degree of absorption of medication; within a few weeks, the patient was started on intravenous analgesia.

Noting the exact location and severity of Mrs. K.'s pain was of great importance post-operatively, as it became obvious after her first surgery that she had developed more problems.

#### *Infection control*

With a history of diabetes and pneumonia, the prevention of infection was an important priority in nursing care. On admission we had instituted a routine of chest physiotherapy to be done q4h which was primarily deep breathing and coughing, and use of an spirometer. Post-operatively, she was treated with intravenous broad-spectrum antibiotics.

Pre-operative infection control measures used on our unit are the standard PhisoHex® baths twice daily for 48 hours pre-op and washing hair the night before surgery.

At the time of surgery, Mrs. K.'s WBC had fallen to within normal limits, and remained so for several weeks post-operatively. Wound cultures taken in the O.R. were negative, as were subsequent cultures of drainage during the early post-operative period.

#### *Psychological support*

During "freeze-up" when boats can no longer be used, Mrs. K. was isolated from her family as the ice was not safe to carry motorized vehicles to our island hospital. Once the ice had frozen solid, however, Mrs. K.'s daughters arrived and stayed in constant attendance for the entire period of her hospitalization.

Language differences posed problems for the nursing staff in that none but the ward aides and secretaries on the unit spoke Cree. Mrs. K. did speak and understand some English, but to ensure accurate transfer of information we often used an interpreter. Mrs. K. offered little spontaneous communication, however, and she seldom complained of anything — not the pain she had constantly, nor the nausea nor the diarrhea. Even when we knew she was in pain and asked about it, she would not answer "yes", so it became a challenge to anticipate her needs.

We tried to keep her and her family informed about her progress, and to prepare her for the various tests and procedures.

A grand-daughter was hospitalized for a time and we ensured family contact by wheeling Mrs. K. out to the ward phone as often as she desired it.

We encouraged independence too by gradually giving her more responsibility in her own care — bathing, feeding and putting on her leg prosthesis.

#### **SURGICAL PROCEDURE NO. TWO**

It became increasingly obvious in the post-operative period that Mrs. K. was not improving; her abdominal pain was worsening, her nausea and vomiting persisted, she exhibited abdominal distention, and her wound issued purulent drainage. A fluid diet was started but was not tolerated. She was scheduled for a second laparotomy in which another 2 1/2 feet of bowel was resected. The bowel showed ischemic necrosis of the jejunum as a result of vascular occlusion in the terminal portion of the superior mesenteric artery. A cholecystectomy was performed at this time as the inflammation and distention seen in the gallbladder in the first surgery had not improved.

After surgery Mrs. K. required constant nursing care, which meant — since our ward staff was comprised of 4 RN's, 1 RNA and several aides — totally readjusting the time schedule to provide adequate care. As it happened, several of the nurses were anxious to see that constant quality care was provided, and so worked double shifts or extra hours.

Medical priorities at this time were the prevention of further vascular occlusion through heparin therapy, low doses parenterally q12h, and maintenance of a good nutritional state through Total Parenteral Nutrition (TPN) or hyperalimentation, consisting of 10 per cent Travesol and Intralipid solutions. This was to be given Mrs. K. intravenously through catheter inserted in an antecubital cutdown site.

For the nursing staff who were unfamiliar with such things as hyperalimentation and the mixing of the special solutions, this was a time of great anxiety. We had to arrange therefore a special inservice program to deal with the basics of TPN and the nursing care involved. In order to ensure adequate flow rates of the intravenous infusion, infusion pumps were used, and the use of these mechanisms had also to be taught to the nurses.

We had the same basic priorities in organizing Mrs. K.'s nursing care, but due to the seriousness of her condition at this time, tasks were more complex than before.

#### *Nutrition and fluid balance*

Oral intake was obviously impossible and so Mrs. K. was on total parenteral nutrition; she also had a straight intravenous line for antibiotic therapy. Both were aided by the use of infusion pumps. Nursing responsibilities at this time included maintenance of flow rates and mixing of the I.V. solutions. Of no small importance too was the charting of intake and output, monitoring of tube drainage, results of urine testing, and laboratory results such as Hgb, electrolytes, BUN and glucose levels.

#### *Infection control*

Due to Mrs. K.'s debilitated condition and diabetes, infection was an ever-looming problem. The patient was maintained on strict isolation of dressings and bedlinens, and her wound dressings which were changed nearly q2h.

#### *Psychological support*

As her condition worsened and her pain increased, Mrs. K. became convinced she would never recover. She asked to receive the last rites of the Catholic church, which we arranged, and she was permitted to have her family nearby as much as possible.

It was a difficult time for the nurses: they cared very much for their patient, and yet they had to cope with continually changing doctor's orders, and the evidence that Mrs. K. was in fact not improving. It was difficult for them to adopt a supportive positive attitude with Mrs. K. and her family when it was apparent to all that her wound was not healing, that her nutritional status remained poor, and that she could not get full relief from her pain.

The situation became still worse when, 48 hours after surgery, the doctors decided she must return to the O.R. for yet a third time for surgical debridement of an infected wound; the wound swabs had shown the presence of clostridium perfringens, pseudomonas and E. Coli. The surgeon was available at our hospital in Moose Factory only two or three days



a week, and to attend to Mrs. K. the hospital had to arrange for a chartered plane to bring him from his home base. The doctors agreed that Mrs. K. would be better in a hospital in the South, under the circumstances, and planned a transfer for her post-operatively.

#### FINAL SURGICAL PROCEDURE

Pre-operatively, we notified Mrs. K.'s family, and the priest; the doctors explained to Mrs. K. with her family both the necessity and the risks of the proposed surgery. The nurses wanted to offer as much support as possible; we were able to arrange a room for the family to sleep in until after the operation.

The final surgery involved debridement of the wound and further bowel resection necessitating an ileostomy, and Mrs. K. returned to the unit with numerous drainage tubes — N/G, Foley catheter, duodenostomy and multiple abdominal drains — as well as a subclavian intravenous line. She was also on oxygen by mask.

Our priorities were as before: to prevent infection by maintenance of strict isolation technique (which was difficult to accomplish while allowing her family liberal visiting privileges, and with the large numbers of medical and nursing staff in attendance), good skin care, relief from pain, nutrition and emotional support.

The next development was disheartening: Mrs. K. had a myocardial infarction post-operatively and went into congestive heart failure. In spite of the obvious negative aspect of this development, Mrs. K. was actually pleased because it meant her condition was too serious to allow her to be transferred to a hospital in southern Ontario as the doctors wished; the family unit in Cree culture is often very close, and Mrs. K. did not want to leave those who were closest to her.

Psychologically, she was prepared to die, and fought the sedatives and analgesia to remain alert. She rejected our constant care, saying that we were "waiting for her to die".

And it was true, Mrs. K.'s prognosis was grave: her white count rose to over 40,000/cu mm, her congestive heart failure worsened, and she developed frequent paroxysmal ventricular contractions and had diminished response to stimuli.

Seven weeks after her admission she died.

For the nursing staff, her death, though inevitable, was a great disappointment; they had come to know Mrs. K. and her family so well, and had learned a great deal about the Cree people and their culture. We all felt we had participated actively, giving as much as we could, to help Mrs. K. in her battle against the insurmountable odds of diabetes, heart disease and radiation enteritis. ♣

## RADIATION THERAPY

**The goal of radiation therapy is to destroy malignant cells without unduly harming the surrounding tissues.**

**Adverse reactions** are influenced by:

- intensity of prescribed dose and degree of exposure: exposure to greater amounts of radiation may cause necrosis of intestine, malabsorption, intestinal obstruction and neoplasia.
- radiosensitivity of cells: most radiosensitive cells are
  - a) rapidly dividing
  - b) poorly differentiated, embryonic, immature
  - c) have increased metabolic activity.
- individual differences: the rate of injury increases in the presence of pre-existing vascular disease, diabetes mellitus, arteriosclerosis, hypertension or existence of past injury to the intestinal tract.

**Specific G.I. effects of radiation:**

- jejunal and ileal injuries are evidenced by crampy periumbilical pain, nausea, vomiting, abdominal distention and obstipation;
  - pathological lesions are usually ulcers which may bleed, perforate and stenose.
- Symptoms are malabsorption, acute and chronic obstruction, abdominal pain.

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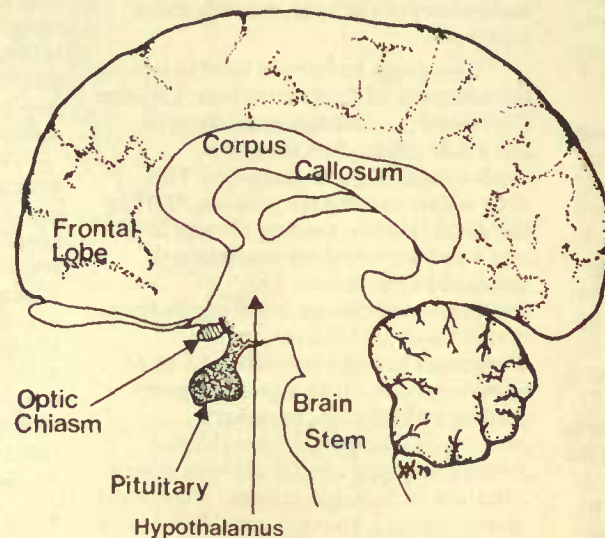
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# ADH

## Antidiuretic Hormone and its Inappropriate Secretion



LOCATION OF PITUITARY GLAND

Mr. Fisher was admitted to the neurological unit with a diagnosis of head injury; he is irritable and complaining of a headache. Mrs. King had major abdominal surgery three days ago; she is lethargic and anorexic. These two apparently normal reactions to two obviously different causes are, in effect, responses to the Syndrome of Inappropriate Antidiuretic Hormone Secretion.

Long thought of as a hormonal imbalance that only concerned neurological personnel, this syndrome is now being recognized as playing a very important role in many other conditions. Malignancies, especially involving the lungs, anesthetics, stress and pain have all been associated with an overproduction of this hormone.

*Muriel Burry Lydia Martens*

Antidiuretic hormone (vasopressin) regulates the body's fluid balance by altering the permeability of the renal tubules and affecting water reabsorption rates. This hormone, which is made up of eight amino acids, is synthesized in the supraoptic nuclei of the hypothalamus (See figure one). It is then transported through the hypophyseal stalk to the posterior lobe of the pituitary gland where it is stored and eventually released.

Osmoreceptors located in the hypothalamus control the synthesis and release of antidiuretic hormone (ADH). These receptors, which are sensitive to the concentration of the plasma are assured an excellent blood supply by the hypothalamic artery which arises from the Circle of Willis. Thus, each minute change in osmolality is readily available to the osmoreceptors. (Osmolality is the measurement of the solute concentration per liter of solution.)

The normal stimulus for the production of ADH is an increase in plasma osmolality, such as in dehydration. The osmoreceptors stimulate the supraoptic nuclei to increase synthesis of the hormone and to transmit impulses to the posterior pituitary to release appropriate amounts of ADH. The hormone enters the general circulation by way of the inferior hypophyseal vein and is carried to the kidneys where its potency is realized.



In the distal convoluted tubules of the kidneys, ADH increases the tubules' permeability to water, allowing a greater reabsorption to take place, thus diluting body fluids. With this dilution, plasma osmolality is decreased and osmoreceptors signal the hypothalamus to reduce the production and release of ADH.

ADH levels are also influenced by baroreceptors in the left atrium of the heart which respond to changes in blood pressure. In the event of hypovolemia, ADH secretion is increased and body fluids conserved through the increased reabsorption of water. Baroreceptor response may also be influenced by one's position; an unconscious patient being nursed supine tends to have high serum levels of ADH because of inadequate atrial filling. This same stimulation may also occur when positive pressure breathing is being used and conversely ADH levels may decrease with negative pressure ventilation.

#### **Syndrome of Inappropriate Antidiuretic Hormone Secretion**

Although ADH is normally secreted in response to stimulation by plasma osmolality there are times when there is an excess produced without this stimulus. This pathophysiological state is termed Syndrome of Inappropriate ADH (S.I.A.D.H.).

Causes are both intracranial and extracranial, ranging from neurological disorders that produce cerebral edema, to malignant diseases, particularly of the lung if the tumor secretes a substance similar to ADH, and to pharmaceutical agents such as anesthetics, morphine and chlorpropamide (Diabinese®). Because of the wide variety of causes, the syndrome is not always recognized until it is fairly well advanced.

Since S.I.A.D.H. occurs when the serum osmolality is normal (280-295 mOsm/kg), the increase in ADH which stimulates an increase in the amount of circulating body fluid results in a relative hyponatraemia (normal serum sodium is 135-145 mEq/l) and a reduction in urine volume, as low as 400 ml/day. This phenomenon is commonly termed "salt wasting" as the body responds to the increased blood volume by reabsorbing less sodium through the renal tubules.

#### **Diagnosis**

The diagnosis of S.I.A.D.H. rests on the combination of a low serum sodium and osmolality with a high urine sodium (normal is 27-287 mEq/24 hr) and a urine osmolality greater than that of the serum. This relationship must exist in the presence of a normal blood urea nitrogen and creatinine.

Mild hyponatraemia (120 mEq/l) causes lethargy, irritability, anorexia and headache. If this is not corrected, the

hyponatraemia becomes severe (110 mEq/l) and nausea, vomiting and confusion may lead to convulsions, coma and death. Cardiac fibrillation becomes a very real threat.

#### **Treatment**

Fluid restriction, the principal treatment of this syndrome, usually corrects the hyponatraemia within seven days. However, as fluids are given only to make up insensible fluid loss, a restricted intake of 500-800 mls/24 hrs is distressing to the patient and family who may not fully comprehend the reasons for the regime. Chronic conditions of S.I.A.D.H. such as inoperable malignancy of the lung, magnify these problems.

Two drugs have been used to relieve the necessity of fluid restriction. Lithium Carbonate, an anti-manic medication, has a side effect of producing a nephrogenic diabetes insipidus. This drug seems to interfere with the ADH in the distal tubules, causing a water loss and a sodium retention secondary to increased aldosterone. The recommended dosage is 900 mg/24 hrs in divided doses. However, many sometimes harmful side effects may be experienced, such as digestive upsets, cardiac arrhythmias, peripheral circulatory collapse, diffuse thyroid enlargement and central nervous system irritation including dizziness, drowsiness and seizures. Lithium is considered to be effective only on a short term basis as with prolonged use it seems to interfere with the action of aldosterone, resulting in further sodium loss. Consequently it is not useful in the treatment of chronic S.I.A.D.H.

Demethylchlortetracycline (demeclocycline) 300 mg, four times daily, has been reported to cause a reversible decrease in renal urinary concentrating ability and thus increases water excretion and resolves the hyponatraemia, again producing a nephrogenic diabetes insipidus. Effectiveness of demeclocycline is noted only after several days of treatment, but few side effects, such as nausea and photosensitivity, are produced. As a result, it is used most frequently with chronic S.I.A.D.H.

If hyponatraemia is so pronounced that the central nervous system is affected, an initial treatment of intravenous hypertonic saline may be given in an attempt to reduce cellular swelling which could cause irreversible cerebral damage. Usually, 500 mls of five per cent sodium chloride is given. The rate should not exceed 75 mls/hour and 50 to 60 mls/hour is considered optimum. As the plasma volume is increased, the proximal tubules of the kidney excrete the sodium so that there is no long term effect to be derived from this method of

treatment. Lasix® (furosemide) may also be given at this time to induce a rapid diuresis.

#### **Nursing responsibilities**

- **Monitoring of fluid balance:** Intake, output and specific gravity of urine should be measured for all patients with cranial disorders in order to detect this syndrome in its early stages.

Once a diagnosis of S.I.A.D.H. has been made, fluid restriction assumes ultimate importance. Fluids should be allocated throughout the twenty-four hours, taking into account medication regimes; giving pills with meals allows fluid rations to be more flexible. Good mouth care and frequent mouthwashes help to alleviate thirst but confused patients must be observed carefully as they may swallow the mouthwash solution.

While body fluids are being retained, urine volume and specific gravity are essential measurements; the specific gravity will be high (1.025) and volume low. Fluid retention is also indicated by daily weight gains that are out of proportion with caloric and fluid intake. Although restless head-injured patients present problems with daily weighing, this measurement is essential to determine if changes in cerebral function are being caused by the disease or injury or by an electrolyte imbalance.

- **Collection of specimens:** Serum and urinary electrolyte and osmolality measurements must be taken on a daily basis. The diagnosis is determined from these levels and the response to treatment is monitored in the same way. Collection of specimens, recording of results, awareness of normal values and significance of variations are all nursing responsibilities.

- **Administration of medications:** Intravenous hypertonic saline with or without Lasix® may be ordered at the critical stage of fluid retention to prevent cerebral damage. Once an initial diuresis has been achieved, treatment may be continued with lithium or demeclocycline. If lithium is used, serum lithium levels should be checked daily, usually before the morning dosage is administered. If the level exceeds 1.5 mEq/l, the physician should be notified before continuing therapy. Mood changes, dizziness, headache and other CNS complaints usually indicate impending toxicity. While methylodopa administration during lithium therapy predisposes the individual to lithium toxicity, aminophylline and acetazolamide decrease its effectiveness. Lithium excretion can be promoted with an adequate fluid and salt intake, and gastrointestinal symptoms may be minimized by administering the medication at mealtimes.



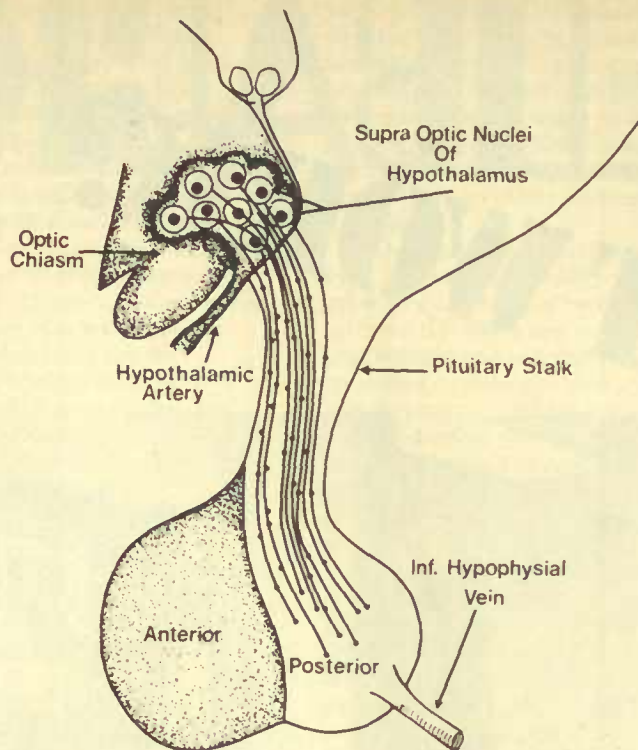


Figure one: PITUITARY GLAND

Demeclocycline, a tetracycline antibiotic, must be administered no less than one hour before nor sooner than two hours after meals. Its absorption may also be impaired by milk and other calcium containing foods. Chronic sufferers of S.I.A.D.H. using long term demeclocycline therapy should be advised to avoid exposure to sunlight or ultraviolet light to prevent severe burns.

• **Education of patient and family:** Understanding the reasons for fluid restriction is of ultimate importance for patient and family compliance with therapy. Cooperation of some neurological patients is not a problem as awareness of thirst is very low with a depressed level of consciousness. However, with other neurological patients the opposite may be true, a lack of concentration and a poor memory demand frequent repetition of instructions. For these patients, family teaching is of prime importance; relatives and friends find it difficult to accept that it is not necessarily good to give someone a drink when it is requested. Both patient and relatives can usually be assured that this is only a temporary restriction.

#### Summary

Neurological nurses are generally aware of S.I.A.D.H. syndrome as it is a commonly recognized complication of many neurological disorders. However, since the causes of the inappropriate secretion may be so diverse, nurses in all fields must be aware of its possibility and

be able to recognize the signs and symptoms at their onset, thereby preventing the complications and distress of hyponatraemia.

As it is difficult and sometimes impossible to differentiate between lethargy and confusion caused by the disease entity and that caused by inappropriate secretion of ADH, the careful monitoring of electrolyte values, daily weights and intake and output records of all patients should become an established regime. ♡

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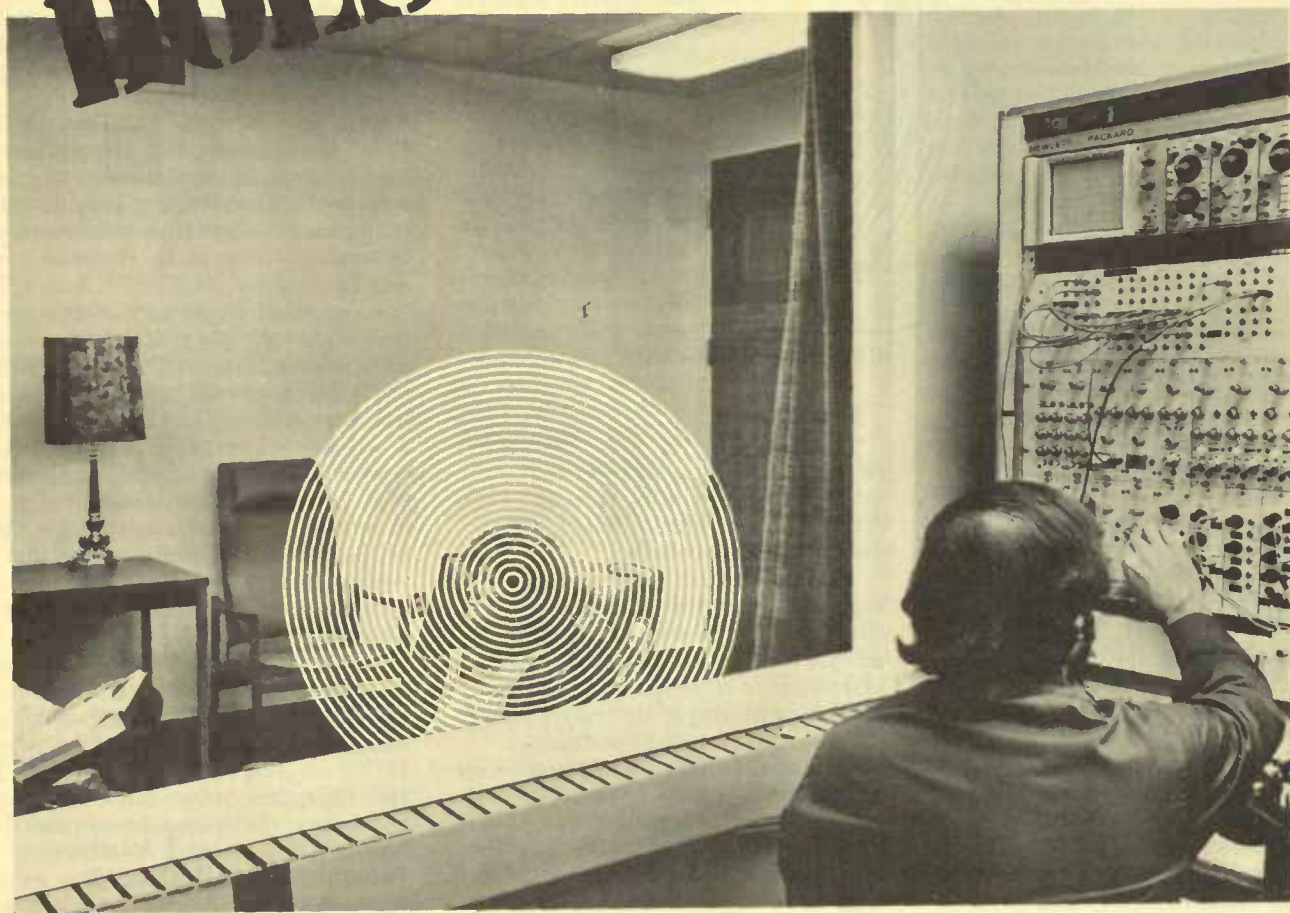
*This paper on ADH was presented by the two authors at the annual meeting of the Canadian Association of Neurological and Neurosurgical Nurses in Halifax, June 1979.*

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# BIOFEEDBACK— DOES IT WORK?



*Cris Burdis*

**What type of patients benefit from biofeedback and behavioral therapy? Do psychiatric patients continue to practice relaxation techniques after discharge and do these techniques remain effective? Can behavioral treatments be carried out effectively by nursing staff?**

Members of the Behavior Modification Treatment Program of the University Hospital, London, Ontario, when they realized the answers to these and similar

questions were not readily available in current literature,<sup>1</sup> decided to do some research on their own. Through practical analysis, a nurse, in consultation with a psychiatrist and a psychologist, obtained some interesting results.

## **Biofeedback — what is it?**

Biofeedback is the term used to describe a relatively new group of techniques whereby an individual is made aware of, and taught increased control of, what are normally considered involuntary physiologic responses.

In psychiatry, biofeedback is used to measure and make an individual aware of tension levels within his body.<sup>2</sup> These

tension levels may be controlled by the autonomic or skeletal muscle system e.g. tachycardia frequently accompanies or results from high anxiety, however through the use of relaxation techniques the tachycardia may be decreased with a consequent reduction of anxiety.<sup>3</sup>

To record the physiological measurements associated with high levels of arousal or tension, a polygraph which includes recordings of heart rate (electrocardiograph), muscle tension (electromyograph), cerebral activity (electroencephalograph), respiration rate and galvanic skin response, is used. This polygraph is used in both the diagnosis and treatment phases.



## Diagnosis

In order for biofeedback to be used effectively in the treatment of any condition, a high activity level from one of the graphs must be noted. If an individual reporting with a migraine or tension headache, for which no organic base has been established, is found to have excessively high tension levels in his head and neck muscles, then it is likely that by learning to relax these muscles he may be able to control pain and headaches. However if there is no visible elevation of tension level, the benefits of biofeedback use are questionable and other treatment modules should be investigated, for example psychotherapy.

High tension levels involving a specific organ may indicate a predisposition to disease. Future heart disease may be predicted when polygraph recordings of an anxious patient reveal heart rate increases with conflict or stress.

## Treatment

Once it is determined that an individual should respond to biofeedback use, treatment is initiated. The individual is instructed in measures to control or reduce tension levels by means of an auditory tone or visual feedback. Using the polygraph, tension levels are measured and a tone which varies with the changing levels of tension recorded, is played back. As the patient uses relaxation techniques, the sound lowers in pitch giving him continuous feedback about the degree of relaxation he is attaining. Often biofeedback is only one of a number of behavioral techniques used as a result of an initial general behavioral assessment.

## The study

Individuals studied had psychiatric diagnoses of migraine headache, tension headaches, anxiety neurosis and conversion reaction. They were referred by their family physician to the Behavioral Modification Treatment Program at University Hospital. In all 49 persons were studied, both male and female, ranging in age from 21 to 78 years; 24 with the diagnosis of anxiety neurosis, 14 with the diagnosis of tension headache, five with migraine headaches and six diagnosed with conversion reaction.

In an initial interview with the behavioral therapist, the patient was given the rationale of behavioral therapy. Then a history of the complaint and a life history were documented with emphasis on behaviors, either learned or genetic which influenced the presenting problem, e.g. complaint of migraine headache with family history of similar complaint. Situational analysis was used to investigate the behavioral components of the pain where stimulus response

patterns were evident, i.e. non-assertive behavior leading to the patient's anxiety. In these situations, the patient was asked to keep a log recording the frequency of his pain and the emotional and cognitive components which might exacerbate or prolong this pain. Physiological measures on the polygraph were also considered part of the assessment procedure.

Once all of this information had been collected, the history was presented to a team of behaviorally oriented therapists that included a psychologist and psychiatrist. A treatment module was then set up and, at regular intervals, the team would meet to discuss ongoing therapy and receive feedback from all disciplines, as the patient might be also undergoing other therapies such as marriage counseling or group psychotherapy at the time.

## Biofeedback treatment

The actual treatment consisted of the application of electrodes to skin surfaces of the muscles near the area where pain was experienced; for instance, the trapezius muscle is often used for occipital headaches and the frontalis muscle for frontal headaches. A sensitive bioelectric amplifier was used to amplify the minute signals generated by muscle cell depolarization and to present them in the form of a line graph. This sensitive measurement can be gauged quite accurately and converted into a tone. The individual, hearing this tone, was told that when he relaxed the involved muscles the pitch of the tone would decrease. To accomplish this, the patient learned relaxation exercises, most commonly the autogenic method devised by Wolfgang Luthe,<sup>4</sup> although other methods such as breathing techniques, hypnosis, yoga exercises, increasing sensory awareness and physical activity, such as jogging may also be recommended.

Autogenic relaxation is based on a method known as passive concentration. The individual reduces tension in one area of his body by concentrating in a passive and casual way on phrases suggesting feelings of heaviness and warmth in that specific part of the body. Passive concentration implies functional passivity towards the intended outcome of the concentrated activity rather than active concentration which demands goal-seeking and interested, alert attention. He says to himself, for example, "my forehead is cool" or "my arm is warm/hot" as opposed to "I want my arm to be warm". Once the patient has mastered the ability to relax in the laboratory situation, he is encouraged to use relaxation exercises at home and prior to facing anxiety situations in his life. A tape recording of the exercises was available for each patient to take home.

In a relatively short number of sessions, averaging about eight, the patient was generally able to relax with concomitant lowering of arousal as measured by the polygraph. All of the patients in this study were treated behaviorally and responded reasonably positively to treatment. Treatment sessions were spread over a period of time ranging from one to six months.

Following termination of therapy, a follow-up questionnaire and interview were administered at three and six months. Physiological base rate measurements were also made of present tension levels. These follow-up sessions included:

- a questionnaire to be filled out before the interview asking about life, mental, environmental or interest changes since therapy
- patient's overview of his therapy
- description of any physical symptoms still present
- degree of relaxation still being practiced
- continued use of coping mechanism learned in therapy
- any changes in sexual behavior patterns
- any mood changes.

All the information collected was recorded briefly and summarized on a graph. Six levels of effectiveness were recorded ranging from level one indicating that the patient was very much worse, level three indicating the same as pretreatment, to level six indicating exceptional improvement.

## Results

Results were examined by dividing the group into diagnostic categories (see Table one). As a group, those with the diagnosis of conversion reaction responded most favorably to biofeedback treatment and six months after therapy were doing better than pretreatment. Patients suffering from migraine headaches also seemed to be coping adequately and as a result were relatively headache-free six months following discharge.

This type of treatment seemed to be exceptionally beneficial in the case of tension headaches. Unfortunately many of these patients did not report for the second follow-up interview. Those suffering from anxiety neurosis proved to be an interesting group that showed more variability in their graphs. Although generally the patients showed an overall improvement, this group had more complex problems than the others, of which physical tension and its reduction played only a small part in their overall personality structure.



Table one — Effectiveness levels following biofeedback

Diagnosis	Follow-up	1	2	3	4	5	6	7
Conversion Reaction n. 6	Three months	1			5			
	Six months				5	1		
Migraine Headaches n. 5	Three months			1	3	1		
	Six months				3			2
Tension Headaches n. 14	Three months			2	4	2	4	2
	Six months			1	3	1	3	6
Anxiety Neurosis n. 24	Three months			2	9	8	3	2
	Six months			2	2	7	5	8

Total — 49

## Levels

1. very much worse
2. somewhat worse
3. same level as pretreatment
4. slight improvement
5. much better
6. exceptionally better
7. no show, refused follow-up or unable to contact

## Conclusions

Generally it would appear that most of the 49 patients in our study improved considerably in a variety of ways and continued to remain at least at a better-than-pretreatment level six months after discharge. Most of them continued to practice relaxation techniques at home at least twice weekly and to utilize relaxation training and coping mechanisms, i.e. cognitive therapy (an exploration into maladaptive thinking patterns that caused anxiety) or assertive skills they had learned, to deal with anxiety.

The muscle tension levels measured at the interview were generally much lower than pretreatment levels, although often slightly higher than at discharge. This would seem to support the theory that lowered physical tension levels occur with increased ability to relax and result in a lowering of pain, as in a tension headache.

Since these results are based only on individuals who were deemed suitable for biofeedback therapy, and only on those who completed the treatment program, it is not possible to do more than delineate some broad categories that describe the type of individual who would not respond well to this type of treatment. These categories are: actively psychotic, severely depressed, unmotivated to therapy and at lower-than-average intelligence.

This study should not be considered a research project as it was not strictly controlled in many areas, since results were gathered from ongoing therapy. However, the comparatively high success rate of treatment, the very few treatment hours required, plus the fact that treatment was carried out by a registered nurse, could contribute considerably to the planning of treatment modules by hospital personnel. With

monetary resources at a minimum in most hospital budgets, and the indication that many patients who are difficult to treat with conventional psychiatry may respond well to biofeedback, a viable alternative is now available. ♦

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Debrisan sucks bacteria and toxins out of decubitus ulcers. The ulcer is quickly cleansed, healthy granulation appears, and healing can begin.

"These (wet, exudative ulcers) averaged two days to clear the superficial infection and five days from the onset of therapy to appearance of good granulation tissue in the ulcer base."<sup>1</sup>

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"Debrisan was commenced and the following day, the smell had disappeared."<sup>3</sup>

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"Debrisan appears to be, in my opinion, just what we as nurses are seeking."<sup>4</sup>

\*Two, if exudation is very heavy.

## Debrisan cleans decubitus ulcers fast.



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Day 0 Infected, heavily exuding decubitus ulcer on left hip.



Day 2 Exudate diminished. Erythema and edema reduced.



Day 14 Clear, healthy granulation base; grafted successfully.



Day 0 Infected exuding decubitus ulcer on knee.



Day 4 Clear, healthy granulation base.



Day 14 Ulcer healing after Debrisan discontinued.



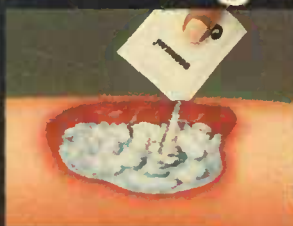
Day 0 Undermined sacral decubitus ulcer infected with *Pseudomonas* and *E.coli*.



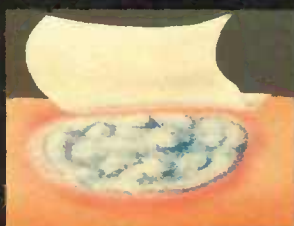
Day 7 Surgically debrided before Debrisan therapy and after 7 days, infection controlled.



Day 28 Appearance on healing.



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Cover with a dressing.



When the beds are saturated (12 to 24 hours later) rinse and wipe them away. Apply a fresh layer of Debrisan.



Concern has been expressed that such an extension of hospital legal liability will result in undue interference in medical practice and, in particular, in the implementation of medical innovations and novel procedures. In respect of the latter, it is feared that hospitals, mindful of legal risks, will prevent the use of such techniques, thereby severely hampering the development of medicine and the potential benefits to patients. On the other hand, the decision has been viewed as a positive step in protecting the public

interest and expectation in ensuring that the public does not receive substandard health care.

The direction the law takes from here will depend on the outcome of the review of this landmark decision by our appellate courts. ♡

*"You and the law" is a regular column that appears each month in The Canadian Nurse and L'infirmière canadienne. Author Corinne L. Sklar is a recent graduate of the University of Toronto Faculty of Law. Prior to entering law school, she obtained her BScN and MS degrees in nursing from the University of Toronto and University of Michigan.*

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\*Unable to verify in CNA Library

## Ovol Drops relieve infant colic.



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Also available in tablet form for adults

**Ovol<sup>®</sup> 80 mg**  
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OVOL is indicated to relieve bloating, flatulence and other symptoms caused by gas retention including aerophagia and infant colic.

#### CONTRAINDICATIONS

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Simethicone 80 mg

OVOL 40 mg TABLETS

Simethicone 40 mg

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Get ready, Get set, GO  
Vancouver, June 22-25, 1980

# HAVE FUN IN BRITISH COLUMBIA



## It's the CNA in B.C. – a pot pourri for you to see

The RNABC is looking forward to June and the CNA biennial meeting here in Vancouver. Vancouver is one of the most beautiful cities in North America: it boasts a natural harbor, a rugged mountain backdrop, lush forests and sandy beaches. Culturally, the city has an abundance of art galleries, museums, theatres and clubs. Restaurants are many and varied, specializing in seafood and ethnic cuisine such as West Coast Indian, Hungarian, Indonesian, French, Greek, Italian...the list is endless.

The RNABC is planning to offer delegates a number of local tours during the off-hours of the June convention. Specific details and registration for these tours will be available once you arrive. In the meantime, however, here are just a few of Vancouver's interesting attractions.



Vancouver waterfront

### Stanley Park

Located within walking distance of downtown, Stanley Park is 404 hectares of natural woodland, nature trails, gardens, picnic sites and playing fields. There's a zoo with monkeys, polar bears and otters. Tennis courts, a miniature golf course, a giant checkerboard and lawn bowling provide lots of recreational options.

The largest and most exciting aquarium in Canada is also located in Stanley Park. Most popular is the Marine Mammal Complex where up to 700 spectators can enjoy performances by playful dolphins and killer whales. The McMillan Tropical Gallery houses a variety of ocean and freshwater fish.

Stanley Park has been described as one of the greatest parks in the world and it certainly lives up to that description.

### Museum of Anthropology

Situated on the Point Grey cliffs overlooking Howe Sound and the North Shore Mountains, the Museum of Anthropology contains a famous collection of Indian artifacts. It is unusual in having most of its collections on permanent view, either in exhibition galleries or in special storage areas accessible to the public. The collection features a unique group of totem poles displayed in the splendid Great Hall. While the best known artifacts represent coastal Indian art, there are other collections from elsewhere in North America, the Pacific Islands, Asia and Africa.

### Chinatown

Vancouver's Chinatown is the second largest in North America, exceeded only by that of San Francisco. Its commercial center is concentrated in a three block Oriental "bazaar" where the treasures of the East are displayed: ivory, jade, colorful brocades and exotic foods. One corner boasts a structure designated by "Ripley's Believe it or Not" as the "World's Thinnest Office Building". Some of Vancouver's most popular restaurants are located in Chinatown.



Chinatown

### Gastown

Gastown is a must for the Vancouver visitor. It is a prime example of urban renewal. Because the area is designated as an historic site, shops are allowed to remain open on Sundays. With its mews and intriguing cul-de-sacs, Gastown is an interesting blend of past and present. Boutiques, specialty shops, antique stores, art galleries and colorful street vendors provide a wide range of choice to the shopper.

### Shopping Malls

Several underground shopping malls are within blocks of each other. Pacific Centre Mall, the largest, connects through its lower floor with the Bay, Eaton's, Four Season's Hotel and the Vancouver Centre Mall which is below Birks. The two malls are below Granville Mall, where most of the downtown movie theatres are located. The Royal Centre Mall, two floors of shops and restaurants, is below the Hyatt-Regency Hotel where the convention is being held. Harbour Centre Mall is below Simpsons-Sears on the waterfront and connects with Gastown.



Downtown Vancouver

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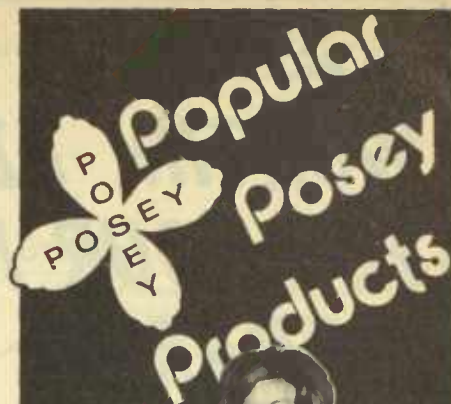
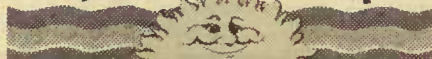
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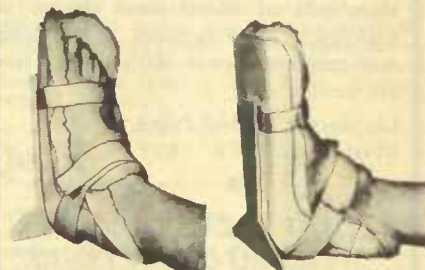
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**Nurses — RNs** — A choice of locations with emphasis on the Sunbelt. You must be licensed by examination in Canada. We prepare Visa forms and provide assistance with licensure at no cost to you. Write for a free job market survey Or call collect (713) 789-1550. Marilyn Blaker, Medex, 5805 Richmond, Houston, Texas 77057. All fees employer paid.

## University Faculty

Applications are invited for clinical faculty positions in an integrated baccalaureate program. Subject to budgetary approval, positions will probably be available for the 1980-81 academic year in the fields of community, long term care, maternal-child and psychiatric nursing. Candidates should have at least a Master's degree, demonstrated clinical proficiency, teaching and scholarly capabilities. Eligibility for registration with the College of Nurses of Ontario is essential. Candidates of both sexes are equally encouraged to apply.

Salary and rank are negotiable and commensurate with qualifications and professional achievement.

Interested persons should send a full resume and the names of three professional referees to:

A. J. Baumgart, Dean  
School of Nursing  
Queen's University  
Kingston, Ontario K7L 3N6

Closing date of applications: April 1, 1980.

**Before accepting any position in the U.S.A. PLEASE CALL US COLLECT**  
**We Can Offer You:**

- A) Selection of hospitals throughout the U.S.A.
- B) Extensive information regarding Hospital— Area. Cost of Living, etc.
- C) Complete Licensure and Visa Service

**Our Services to you are at absolutely no fee to you.**

**WINDSOR NURSE PLACEMENT SERVICE**

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## Miscellaneous

**Adventure Holidays:** Camping Safaris, Overland Expeditions and Fun Experiences. We offer trips from one week to 3 months in: Canada, USA, Europe, Africa, Asia, South and Central America, Australia, New Zealand and the Caribbean. For free catalogue, apply to: Goway Travel, 53 Yonge St., Suite 101, Toronto, Ontario M5E 1J3. Phone: 416-863-0799. Telex: 06-219621.

## Nursing in the Sunny Palm Beaches

Picture yourself in the sunny Palm Beaches working at the most prestigious hospital in Florida. Good Samaritan Hospital has maintained the tradition of being the first in the latest hospital services and facilities. Our good name and outstanding history attest to our success.

A 326 bed, J.C.A.H. accredited hospital offering attractive salaries and benefits including:

- Active in-service orientation
- Continuing educational programs
- 37 1/2 hour week
- 5 day week
- No shift rotation
- Education and experience differential
- Fully paid Blue Cross/Blue Shield
- Shift differential and other employee benefits
- Seasonal employment welcome
- Patient-mix 90% under age 65

We will sponsor the appropriate employment Visa for qualified applicants. Attractive efficiency apartments available at far below commercial rates, overlooking the beautiful Lake Worth and located across the boulevard from the hospital.

Write:

Director of Personnel (305) 655-5511  
Good Samaritan Hospital  
Flagler Drive at Palm Beach Lakes Blvd.  
P.O. Box 3166  
West Palm Beach, Fla. 33402



These positions are open to both men and women. Apply in writing referring to Competition Number immediately.

**Director, School of Nursing**  
Competition No. NC-937

The Department of Health and Community Services, Institutional Services, Brandon Mental Health Centre, requires a person to be responsible for organization and implementation of Psychiatric Nursing education programs, including affiliating, refresher and other programs; liaising with external agencies in arranging academic and field experience; overall supervision and direction of faculty and other related activities of the School, including general administrative duties and involvement in educational research.

Degree in Nursing with psychiatric nursing experience, and several years experience in nursing education.

Salary Range: \$19,168-\$26,168 per annum.

**Assistant Director of Nursing Education**  
Competition No. CN-636

The Department of Health and Community Services, Institutional Services, Brandon Mental Health Centre, requires a person to be responsible to Director, Nursing Education for planning, implementation, and assessment of a Psychiatric Nursing Diploma program. Duties include coordinating activities for both classroom and clinical experience, and committee work at middle management level.

Baccalaureate degree in nursing with teaching experience. Extensive background in psychiatric nursing, preferably with RN and RPN licences.

Salary Range: \$18,453-\$25,152 per annum.

Civil Service Commission  
340 - 9th Street  
Brandon, Manitoba  
R7N 6C2

# Wish you were here



## ...in Canada's Health Service

Medical Services Branch of the Department of National Health and Welfare employs some 900 nurses and the demand grows every day.

Take the North for example. Community Health Nursing is the major role of the nurse in bringing health services to Canada's Indian and Eskimo peoples. If you have the qualifications and can carry more than the normal load of responsibility... why not find out more?

Hospital Nurses are needed too in some areas and again the North has a continuing demand.

Then there is Occupational Health Nursing which includes counselling and some treatment to federal public servants.

You could work in one or all of these areas in the course of your career, and it is possible to advance to senior positions. In addition, there are educational opportunities such as in-service training and some financial support for educational leave.

For further information on any, or all, of these career opportunities, please contact the Medical Services office nearest you or write to:

Medical Services Branch  
Department of National Health and Welfare  
Ottawa, Ontario K1A 0L3

Name

Address

City

Prov.



Health and Welfare  
Canada

Santé et Bien-être social  
Canada





## Offers R.N.'s An UNUSUAL OPPORTUNITY.

A.M.I. Will FURNISH One Way AIRLINE TICKET to Texas and \$500 Initial LIVING EXPENSES on a Loan Basis. After One Year's Service, This Loan Will be Cancelled.

**AMI** American Medical International Inc.

HAS 50 HOSPITALS THROUGHOUT THE U.S.

Now A.M.I. is Recruiting R.N.'s for Hospitals in Texas. Immediate Openings. Salary Range \$11,000 to \$16,500 per Year.

You can enjoy nursing in General Medicine, Surgery, ICC, CCU, Pediatrics and Obstetrics

A.M.I. provides an excellent orientation program, in-service training



U.S. Nurse Recruiter

P.O. Box 17778, Los Angeles, Calif. 90017

Without obligation, please send me more information and an Application Form.

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE (\_\_\_\_) \_\_\_\_\_  
LICENSES: \_\_\_\_\_  
SPECIALTY: \_\_\_\_\_  
YEAR GRADUATED: \_\_\_\_\_ STATE: \_\_\_\_\_

## Head Nurse

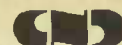
### Operating Room

Applications are invited for the above afternoon shift position. The Department is comprised of 30 surgical theatres covering all specialties including open heart, neurosurgery and kidney transplants. The incumbent would be responsible for co-ordinating emergency cases and for completion of the elective slate.

Applicants must have B.C. Registration plus a minimum of four years clinical and administrative experience. Post basic nursing administration course or BSN preferred. Demonstrated leadership and interpersonal skills essential. Weekends and statutory holidays off. Current 1979 rate \$1,500 - \$1,772 per month (1980 rates under review). Excellent benefits including medical, dental coverage and four weeks vacation after one year.

Please submit resume to:

Mrs. J. MacPhail  
Employee Relations  
Vancouver General Hospital  
855 West 12th Avenue  
Vancouver, B.C.  
V5Z 1M9



## COLLEGE OF NEW CALEDONIA Nursing Instructors

Located in the geographic centre of beautiful British Columbia the College of New Caledonia serves a region of 120,000 people. Applications are invited for positions of full-time Nursing Faculty at the College of New Caledonia for the 1980-81 academic year.

**Qualifications:** Applicants must have a Baccalaureate Degree and must be registered or eligible for registration in British Columbia. Preferably applicants will have two years of nursing practice and teaching experience. In particular Medical-Surgical Nursing experience is preferred.

**Salary:** \$18,050.00 to \$32,450.00 per annum. Placement dependent upon qualifications. Relocation assistance is also available.

Letters of application with the names of three references should be submitted to:

L. Winthrop  
Personnel Officer  
College of New Caledonia  
3330 - 22nd Avenue  
Prince George, B.C.  
V2N 1P8

Phone enquiries to the Personnel Officer at  
604/562-2131

## Are You a Nurse?

## Here's an Opportunity To Be One.

### Primary Nursing

.....at the New Regional Hospital means having direct responsibility for the nursing care of your patient, his family, and working with the doctor as a colleague.

### Accountability

.....as a primary nurse means the outcome of your patient's care is the measure of your effectiveness.

### Satisfaction

.....results from your role as a professional and the significant part you play in the care of your patient.

PUT IT TOGETHER with the new 300 bed Fort McMurray Regional Hospital Opening in November, 1979.

Want to know more about your opportunities in our total patient care facilities?

Call Penny Albers at (403) 743-3381  
or  
Write for an information package:

Personnel Department  
Fort McMurray Regional Hospital  
Fort McMurray, Alberta  
T9H 1P2

## Co-Ordinator Surgical Nursing Services

This 1100 bed community and teaching hospital invites applications for the position of Co-ordinator - Surgical Nursing Services. The area components are five nursing units plus a four bed intensive care unit, totalling 146 beds.

This person will be responsible for the overall delivery of quality patient care and management of the surgical services including budget control, staffing, staff development and other administrative duties.

Applicants must have an appropriate degree and significant clinical experience.

Please forward a resume detailing experience and qualifications to:

Vivian Walwyn  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C.  
V6H 3N1  
(604) 876-6767, local 271



## Registered Nurses

Come to work in scenic Corner Brook!

Registered nurses are needed for this 350 bed Regional General Hospital, with detached 60 bed Special Care Unit, serving the West Coast of Newfoundland.

The hospital offers good fringe benefits such as four weeks annual vacation and eight statutory holidays plus birthday holiday. In addition there is a hospital pension plan and a group insurance plan for all permanent employees.

Accommodation and assistance with transportation is available.

Negotiated Salary Scale:

1 January, 1979 — \$12,771.00 — 15,429.00

1 January, 1980 — \$13,410.00 — 16,199.00

(Contract not yet signed)

Service Credits recognized.

Interested applicants apply to:

Mrs. Shirley M. Dunphy  
Director of Personnel  
Western Memorial Regional Hospital  
P.O. Box 2005  
Corner Brook, Newfoundland  
A2H 6J7

## OPPORTUNITY

# Alberta

## Clinical Nurse Specialist

Alberta Hospital, Ponoka, a 500 bed accredited active treatment psychiatric facility, is now seeking applications from creative nurse specialists seeking a challenging career opportunity.

**Duties:** Acts as a consultant by assisting the nursing team in nursing diagnosis, and by assisting other nurses who are seeking new care approaches. Acts as an Educator in order to optimize Health Care Standards. Acts as a Change Agent in order to improve the quality of care by utilizing skills and theories of human relations. Acts as a Researcher by utilizing valid research findings for patient care and by contributing to research activities in order to develop and test concepts and nursing theories. Performs other duties as required.

**Qualifications:** Graduation from a recognized School of Nursing plus considerable related experience, including consultative experience. Must be eligible for registration in an Alberta Association. Equivalencies considered. Baccalaureate or Masters Degree in Mental Health and/or Behavioural Sciences preferred.

**Salary:** \$18,024 - \$22,596

**Competition #9212-5**

This competition will remain open until a suitable candidate has been selected.

Apply to:

Personnel Director  
Alberta Hospital  
Box 1000  
Ponoka Alberta  
T0C 2H0

## Registered Nurses

1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including:

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education Programs.  
Post Graduate Clinical Courses in Cardiovascular—  
Intensive Care Nursing and Operating Room Nursing.

Apply to:

Recruitment Officer — Nursing  
University of Alberta Hospital  
8440 — 112th Street  
Edmonton, Alberta  
T6G 2B7



## University of Alberta Hospital

Edmonton, Alberta



## Overseas Opportunities NURSES

CUSO has openings for public health nurses and nursing instructors in Africa and Papua New Guinea. Applicants must have Canadian qualifications and be prepared to work with limited supplies and equipment. Travel is an important component of community health care work, while nurse instructors are usually attached to nursing colleges.

**Qualifications:** Degree and/or Public Health Nursing experience is essential.

**Contract:** 2 years.

**Salary:** Low by Canadian standards but sufficient for an adequate lifestyle.

Couples will be considered if there are positions for both partners.

For more information, write:

CUSO Health-DI Program  
151 Slater Street  
Ottawa, Ont. K1P 5H5

## Part Time Hospital Representatives

For  
Montreal Toronto Vancouver Edmonton  
Winnipeg Regina Calgary

We are a new company formed to sell specialized equipment and apparatus primarily to **Hospitals and Clinics**.

We need part time representatives in the above seven territories and invite applications from qualified nurses, or persons with a suitable medical auxiliary qualification, who are keen to sell for about four (4) hours per day. Full training will be given in all aspects of our limited but technical product line.

We will provide a car and we will pay good commission on all sales achieved.

This is a unique opportunity particularly for mature people, with suitable medical backgrounds, to embark on a new and rewarding career pathway, despite some daily domestic commitments.

Please send your resume to:

Circomedic Laboratories Limited  
12285 Yonge Street  
Richmond Hill, Ontario L4C 4Y6

International Grenfell Association requires

## Registered Nurses, Public Health Nurses and Nurse-Midwives (R.N.)

for Northern Newfoundland and Labrador.

The International Grenfell Association provides Medical Services in Northern Newfoundland and Labrador. It staffs four hospitals, seventeen nursing stations and many public health units. Our main hospital is a 150 bed accredited hospital situated in scenic St. Anthony, Newfoundland. Active treatment is carried on in Surgery, Psychiatry, Medicine, Pediatrics, OBS/GYN, and Intensive Care.

Orientation and active Inservice Program provided for staff. Salary based on government scales; 37 1/2 hrs. per week. Rotating shifts. Excellent personnel benefits include liberal vacation and sick leave. Accommodation available. Return air fare paid on a completion of a one year service.

Apply to:

Scott Smith  
Personnel Director  
Curtis Memorial Hospital  
International Grenfell Association  
St. Anthony, Newfoundland A0K 4S0

## The Grande Prairie Hospital Complex is recruiting full-time and casual nurses.

Current vacancies are in Out-Patients, Intensive Care, Medical, and Auxiliary.

Anticipated vacancies in other units.

Apply to:

Personnel Director  
Grande Prairie Hospital  
10409 - 98 Street  
Grande Prairie, Alberta  
T8V 2E8

Telephone: 532-7711,  
Extension 78

## Royal Jubilee Hospital Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

## Registered Nurses

**Shaughnessy Hospital** is an 1100 bed multi-level teaching hospital. We offer B.C. Registered Nurses the following employment opportunities.

- Full-time, part-time or on-call positions: Spinal Cord Injury Unit, Intensive Care areas, Rehabilitation and Assessment, Long Term Care, Psychiatry, Medical and Surgical.

Please apply in writing or phone:

Vivian Walwyn  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C.  
V6H 3N1

(604) 876-6767, local 271

## Waterford Hospital Career Opportunities For Registered Nurses

The Waterford Hospital, a fully accredited 400 bed Psychiatric Institution, affiliated with Memorial University School of Nursing and Medical School, has openings for Registered Nurses in all services, including new, expanded, and acute care services.

An orientation program is offered. Salary is on the scale of \$12,048 - 14,555 per annum. A Psychiatric Service Allowance of \$1,329 per annum is available in addition to basic salary. Both salary and allowance presently under review.

The Hospital is close to all amenities: shopping, transportation and recreation facilities.

Accommodations available in Hospital Residence at nominal cost.

Applications in writing should be addressed to the undersigned:

Personnel Director  
Waterford Hospital  
Waterford Bridge Road  
St. John's, Newfoundland  
A1E 4J8  
Telephone Number: (709) 368-6061, ext. 341

## Registered Nurses

418 bed fully-accredited general hospital in Sudbury is looking for nurses who are willing to be challenged with a wide variety of nursing care.

Candidates must be eligible for registration with the Ontario College of Nurses. Bilingualism is a definite asset.

Positions are opened for medical/surgical, rehabilitation and long-term care for full-time and part-time employees immediately; and part-time in our Renal Dialysis Unit. More positions will be available in January due to the expansion of our Long Term Care Program.

Salary: according to O.N.A. contract

Please apply in writing to:

Director of Personnel  
Hôpital Laurentien - Laurentian Hospital  
41, ch. du lac Ramsey  
Sudbury, Ontario  
P3E 5J1

## Director of Nursing

**Palmerston and District Hospital**

Applications are invited for the position of Director of Nursing of this fully accredited 40 bed active treatment Hospital.

### Position

The Director of Nursing is directly responsible to the Administrator for the quality of nursing care, the development and maintenance of the nursing care program, the overall administration and staffing of patient services of the unit including O.R. and ambulatory care unit.

### Person

The applicant must be eligible for registration in the Province of Ontario.

The selection will place strong emphasis on the applicants philosophy of administration and the applicants combination of demonstrated administrative skills, appropriate experience and educational background.

Please send confidential resumé to:

Mr. R. G. Emmerson  
Administrator  
Palmerston and District Hospital  
P.O. Box 130  
Palmerston, Ontario N0G 2P0



## Assistant Director Nursing Service

The Calgary General Hospital invites applications for the position of assistant director for the Division of Obstetrics, Gynecology, and Pediatrics in the Department of Nursing Service. This Division consists of six (6) nursing units, including an Intensive Care Nursery and has a total of 180 beds and 65 bassinets. The Division is committed to the family centred approach to patient care.

The successful applicant will be a registered nurse with advanced preparation and considerable experience at the supervisory or management level.

The 1979 salary range for this position is from \$21,760 to \$24,180 per year and is subject to review in January, 1980. A comprehensive range of employee benefits is offered including full family dental care.

Applications, with a detailed resume of education and experience, may be submitted in confidence to:

Director of Personnel  
Calgary General Hospital  
841 Centre Avenue East  
Calgary, Alberta T2E 0A1

## OPPORTUNITY

# Alberta

## Nurses

Applications are invited for positions at Alberta Hospital, Edmonton, a 650 bed active treatment psychiatric hospital, located 4 km. outside of Edmonton.

Successful candidates must be graduates from a recognized School of Nursing and eligible for registration in their professional association; willing to work shifts. Vacancies exist in Admissions, Forensic, Rehabilitation, and Geriatric Services. **Note:** Transportation is available to and from Edmonton. Accommodation is available in the Staff Residence.

Salary \$1,229 — \$1,445 per month (Starting salary based on experience and education)

Competition #9184-9

This competition will remain open until a suitable candidate has been selected.

Qualified persons are invited to phone, write or submit applications to:

Personnel Administrator  
Alberta Hospital, Edmonton  
Box 307, Edmonton, Alberta  
T5J 2J7  
Telephone: (403) 973-2213

## Registered Nurses

Join us at one of the three Hospitals of the South Saskatchewan Hospital Centre, Regina, Saskatchewan.

- Provincial Capital
- University Centre

Nursing Areas: • Intensive Care • Plastics  
• Medicine • Psychiatry  
• Chronic Care • Obstetrics • Rehabilitation  
• Coronary Care • Orthopaedics • Surgery  
• Emergency • Paediatrics • Urology

Interested applicants should be eligible for registration in Saskatchewan.

For further information on nursing opportunities write to:

Nursing Recruitment Officer  
South Saskatchewan Hospital Centre  
4101 Dewdney Avenue  
Regina, Saskatchewan S4T 1A5

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Prov. \_\_\_\_\_

Postal Code \_\_\_\_\_

## Newfoundland



### Public Service

#### Psychiatric / Mental Health Nursing Consultant

**Duties:** Maintains a working relationship with community agencies and government departments involved with mental health programs, the position acts as consultant in the developmental, administrative and clinical aspects of psychiatric nursing in hospital based programs in the province and assists in the development of professional standards for education and practice.

**Qualifications:** Experience in Psychiatric nursing, a master's degree in psychiatric nursing, eligibility to register as a nurse in the province of Newfoundland or any equivalent combination of experience and training.

Salary: \$22,761 - \$28,178 (EFFECTIVE January 1, 1980)

Competition Number: H. PNC. 190

Financial Assistance towards relocation is available.

Applications may be submitted in confidence to:

Public Service Commission  
16 Forest Road  
St. John's, Newfoundland  
A1C 2B9

This Competition is open to both men and women.





**Government of  
Newfoundland & Labrador**

**Public Notice**

**Cottage Hospital Nurse 1's**

Applications are invited for appointment on a permanent or short term basis to the Nursing Staff of the Cottage Hospitals at:

**Bonne Bay**

**Harbour Breton**

Salary for Cottage Hospital Nurse 1, annual, sick leave, statutory holidays and other fringe benefits in accordance with Nurses Collective Agreement.

Living-in accommodations available at reasonable rates, also laundry services provided.

Applications should be addressed to:

**Director of Nursing  
Cottage Hospitals Division  
Department of Health  
Confederation Building  
St. John's, Newfoundland  
A1C 5T7**

**Lorne A. Klippert, M.D.  
Deputy Minister**

**Head Nurse**

**Spinal Cord Injury Unit**

The Spinal Cord Injury Unit is a tertiary care referral center. We take a multi-disciplinary team approach to patient care.

This is a challenging career opportunity for an individual who will be responsible for the management of a 22 bed area which includes an Intensive Care Unit. Preference will be given to applicants with a Baccalaureate degree.

If you have:

- proven administrative experience in a Head Nurse capacity,
- effective communication skills,
- proven abilities in leading and developing staff,
- and clinical expertise in neurology, neurosurgery or orthopedics .....

Please apply, including a resume to:

**Vivian Walwyn  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C., V6H 3N1  
876-6767, local 271**

**The University of Lethbridge**

invites applications and nominations for

**Director of the School of Nursing**

The School will develop and offer a post-basic baccalaureate program leading to a Bachelor of Nursing degree.

Desirable qualifications include:

1. an advanced degree and experience in Nursing,
2. experience in Nursing education and curriculum development at the University level,
3. the capability of dealing effectively with external organizations involved in health care education and delivery.

The appointment will commence on July 1, 1980 or earlier.

Applications and nominations will be accepted until February 28, 1980, and should be sent to:



**Vice-President (Academic)  
University of Lethbridge  
4401 University Drive  
Lethbridge, Alberta  
T1K 3M4**

**Director of Nursing**

Applications are invited for this senior management position in a fully accredited multi-disciplinary treatment complex of 406 beds, including extensive out patient programmes. Reporting to the Executive Director, fully responsible for organization, planning, administration and operations of nursing care functions.

Candidates must have current registration in Ontario, B.Sc.N. or Masters degree preferable, with demonstrated competent leadership abilities and previous nursing administrative experience at a senior level.

Applicants are requested to submit a comprehensive resume and salary expectations to:

**G. E. Pickard  
Executive Director  
Windsor Western Hospital Centre Inc.  
1453 Prince Road  
Windsor, Ontario  
N9C 3Z4**



## Nursing Opportunities in Vancouver Vancouver General Hospital

If you are a Registered Nurse in search of a change and a challenge — look into nursing opportunities at Vancouver General Hospital, B.C.'s major medical centre on Canada's unconventional West Coast. Staffing expansion has resulted in many new nursing positions at all levels, including:

**General Duty (\$1305. - 1542.00 per mo.)**

**Nurse Clinician**

**Nurse Educator**

**Supervisor**

Recent graduates and experienced professionals alike will find a wide variety of positions available which could provide the opportunity you've been looking for.

For those with an interest in specialization, challenges await in many areas such as:

**Neonatology Nursing      Intensive Care  
   (General & Neurosurgical)**

**Inservice Education      Cardio-Thoracic Surgery**

**Coronary Care Unit      Burn Unit**

**Hyperalimentation      Paediatrics  
Program**

**Renal Dialysis & Transplantation**

If you are a Nurse considering a move please submit resume to:

Mrs. J. MacPhail  
Employee Relations  
Vancouver General Hospital  
855 West 12th Avenue  
Vancouver, B.C. V5Z 1M9

## Director of Nursing

The Holy Cross Hospital, a 500 bed fully accredited hospital with regional Cardiovascular services in Southern Alberta invites applications for the position of Director of Nursing.

The Director of Nursing is responsible for administration and professional activities of the Nursing Department. This position requires leadership in planning, developing and evaluating nursing programs. This leader also assumes responsibility for quality assurance of nursing practice throughout the hospital.

**Qualifications:** Registered in the Province of Alberta. A Master's degree preferred but consideration will be given to a baccalaureate candidate. The successful candidate will have demonstrated leadership abilities and accomplishments with progressive and creative approach.

**Experience:** A minimum of 5 years' progressive nursing experience.

Please send a complete resume indicating qualifications, experience, date available and salary expected to:

Director of Personnel  
Personnel Department  
Hospital District #93  
940 - 8th Avenue S.W.  
Calgary, Alberta T2P 1H8



# General and Psychiatric Nurses Hong Kong

## Up to HK\$3,745 p.m.

Applications are invited for appointment as Registered General Nurses or Registered Psychiatric Nurses. Successful candidates will perform nursing and supervisory duties in Government hospitals and clinics in Hong Kong.

Qualifications required:—

- A. (i) General Nurse:—  
Certificate of Registration (Part I) issued by the Nursing Board of Hong Kong.
- (ii) Psychiatric Nurse:—  
Certificate of Registration (Part II) issued by the Nursing Board of Hong Kong.
- B. Fluent Cantonese essential; knowledge of other Chinese dialects an advantage.
- C. Applicants possessing other professional qualifications should enclose detailed transcript of their nursing training and state qualifications obtained in their applications.

Salary scale:—

- (i) General Nurse: HK\$2,465 to HK\$3,565 p.m.
- (ii) Psychiatric Nurse: HK\$2,605 to HK\$3,745 p.m.

Starting salary will depend on post-qualification experience.

Successful candidates will be appointed on probation for two years and if their service is satisfactory, they will be confirmed to the permanent and pensionable establishment. They will be provided with a passage to Hong Kong plus a baggage allowance. Other benefits include generous paid leave, medical and dental attention, free uniform and laundry and in appropriate cases, education allowances for children.

Applicants should send full resume of training, qualifications and experience to the Hong Kong Government Office, 6 Grafton St., London W1X 3LB, England before 29th February, 1980.

**Hong Kong Government**





# calendar



## February

**An Emergency Nursing Symposium** will be held at the University of Calgary, February 20-21. Contact: *Mary Hammond, Coordinator, Continuing Education for Nurses, University of Calgary, 2920 24 Ave. N.W., Calgary, Alberta, T2N 1N4.*

**"A Day in Rehabilitation"**, a seminar for nurses, therapists and physicians, will be held February 20 at the Oshawa General Hospital. Contact: *M. Papp, Oshawa General Hospital, 24 Alma St., Oshawa, Ontario, L1G 2B9.*

**The Learning Disabled: A Community Affair** is a seminar presented by Simon Fraser University, February 21-23 at the Bayshore Inn, Vancouver. Contact: *Continuing Studies, Simon Fraser University, Burnaby, B.C., V5A 1S6.*

**Occupational Health-Toxic Agents**, a five-day seminar will be held at the Citadel Inn in Halifax, N.S. on February 25-29 and will be repeated in Toronto, March 24-28.

Contact: *Conference & Seminar Services, Humber College, Box 1900, Rexdale, Ontario, M9W 5L7.*

## March

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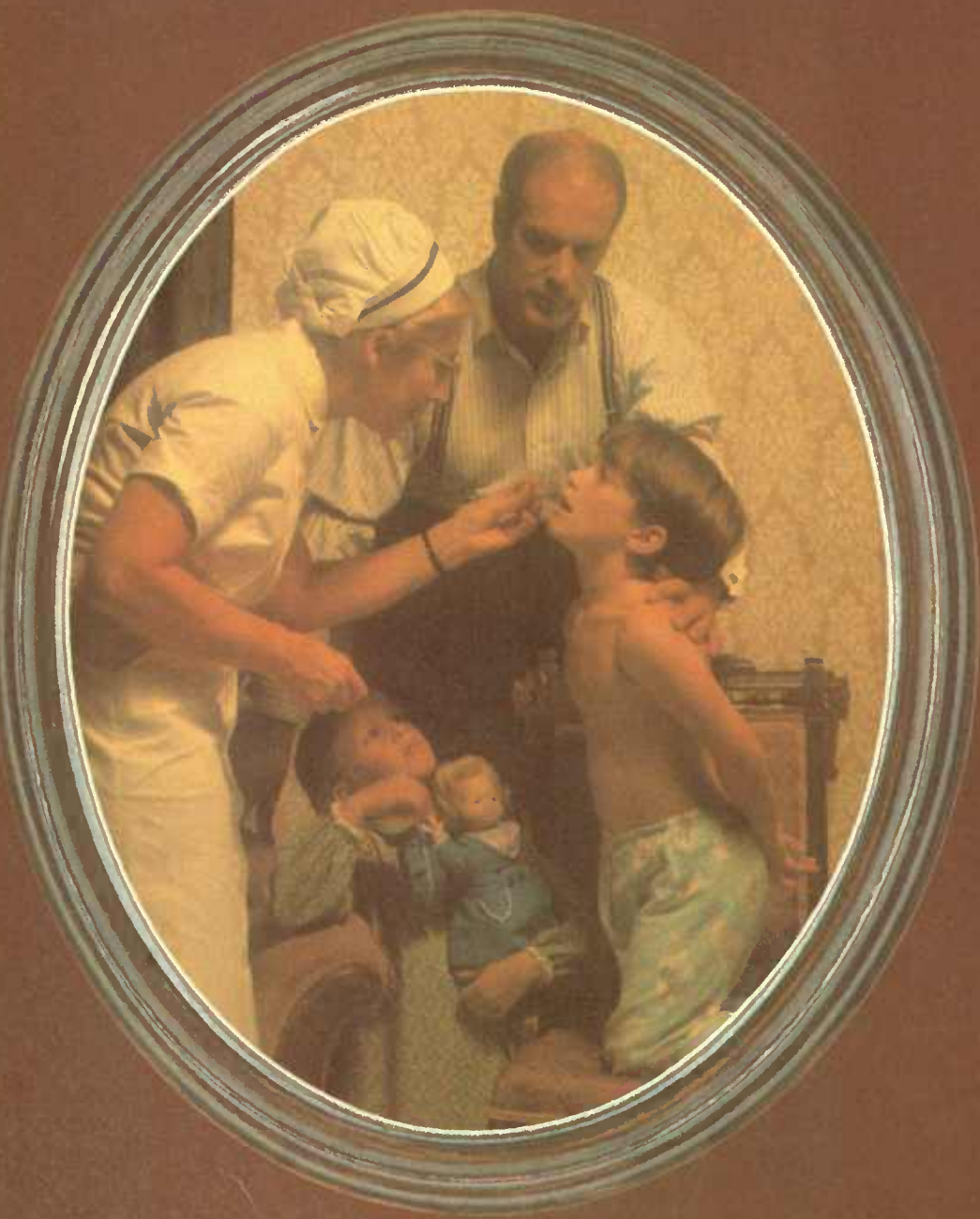
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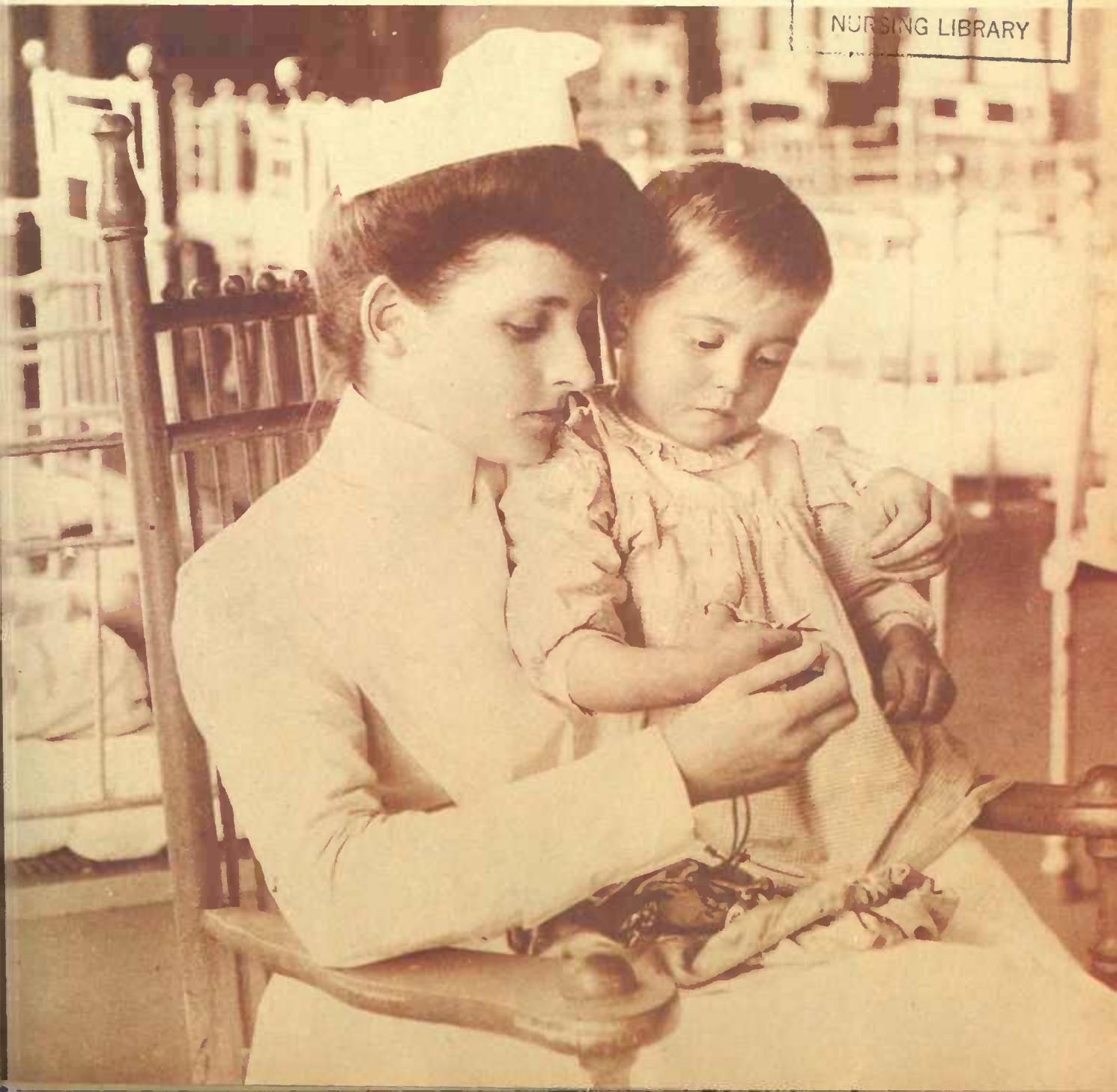
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# The Canadian Nurse

March 1980

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# Mirror, Mirror on the Wall

## A look at nursing's image — now and in the future

The stereotypes are everywhere: on the soap operas of daytime television, nurses are damp-eyed creatures who pine for the love of the nearest eligible doctor; a television commercial several years ago advertising a well-known toilet bowl cleaner featured an actress dressed as a nurse claiming, "We don't fool around, we use a professional!"; heart-throb fiction churned out by the paperback thousands centers on nurse-heroines in love with doctors who remain oblivious to their charms. A movie theatre in Hull, Quebec, features a film entitled "Des infirmières très privées" (very private nurses) with the caption 'find out what to do until the doctor comes!'

There can't be a nurse who hasn't seen and been annoyed by the image of nurses in the media — the nurse of stage, screen and paperback is a weak-willed creature who relies on the doctor for direction, both personal and professional, and whose only real aim in life is to find some nice man, get married and have children.

We don't believe in these stereotypes, but does the average member of the public? Do doctors? Several recent studies say no.

A study in the United States quizzed a number of people about what they thought nurses' jobs really involved and how much education they had to have. The result was, according to *Nursing Outlook*, "the public as represented by these respondents generally believed that nurses are better educated than they actually are." An informal survey conducted by *Nursing* last year asked doctors and nurses for their opinions on the nursing profession and came to the somewhat startling conclusion that doctors often have a higher opinion of nurses than nurses do. One statement the nurses made was "doctors don't have the slightest idea of the care we give, adding that they thought

they spent more than 50 per cent of their time doing direct patient care. The doctors surveyed agreed. Countering the assumption that doctors viewed nurses as assistants, not colleagues, was the information that the 225 doctors surveyed ranked nurses higher in their esteem than the other helping professions such as pharmacists, dietitians or hospital administrators.

What does all this mean? That nursing 'doth protest too much'?

The roots of nurses' rather discouraging tendency to downgrade their own profession probably lie in the history of the nursing profession as a whole. It is true that the first nurses were often prostitutes or at least vulgar women who did not mind doing physical tasks for other people. It is also true that the profession has traditionally been made up chiefly of women. This explains a great deal. As Marjorie Keller wrote in her essay on the effect of sexual stereotyping on the development of nursing theory, the stereotype has been that women's work was non-intellectual and centered in practice: "Perhaps nursing was long considered a practice discipline not only because it was practiced by women, but also because it was slow to move into universities." She added that women have historically tended to downgrade or underplay their intellectual abilities and to display "excessive humility".

True enough, many a nurse can recall being discouraged by her family and friends from going into nursing because of the feeling that she would be wasting her intellect — "You're too smart to be a nurse." Denise Benton wrote in "You Want to Be a What?" that "nursing has a history of attracting applicants by a passive rather than active choice."

It does not help that nursing itself is divided today on the question of what nursing really is. Many feel

that the only 'real' nursing is direct bedside care of the sick; others see the development of nursing theory and research as a priority. There is some suggestion that the nurses produced by the educational systems today are not as 'good' as in the old days, that they do not have the same sense of devotion or dedication. If this is true, is it the fault of nursing programs, or merely a reflection of the kind of people going into them today? As one nurse admitted, no young woman in her right mind would volunteer today for the hospital-based programs of twenty years ago (ten?).

The profession has undergone enormous changes; it will probably see many more. It must if it is to survive, say many educators. An excerpt from the book *Nurse* by Peggy Anderson telescopes the metamorphosis:

"Another problem for many nurses is that nursing is undefined. What is a nurse? Nurses have been debating that question for years. A nurse used to be a physician's handmaiden. My husband's grandfather...remembered a time when nurses stood up and saluted doctors. Central's director of nursing, a woman in her forties, remembers the days when nurses had to stand and give doctors their chairs when they came into the nurses' stations.

"This attitude has not disappeared. But nurses are stepping out of that mold...Many nurses want to bring their own intelligence to the job and are becoming more aggressive about doing so. I think a nurse must make decisions that affect what she's doing. If she's a robot, she's nothing."

There are many nurses who welcome this change and the accompanying increase in responsibility, but there are others who are content to just 'do the job', grouse about how little the public and doctors seem to think of nurses, and go home to their social lives. There are those who actually

impose negative sanctions on their colleagues who want to improve themselves or who have an obvious need to learn. A staff nurse tells of how she was discouraged by other nurses on her floor from going to see a cardiac catheterization with one of her patients; she had never seen one and it was quite a common procedure on her unit. Her colleagues asked, "What do you want to do *that* for?", and the head nurse was reluctant to grant her the time off the ward. Benton emphasizes this in her paper, saying that nurses tend to exert pressure which "serves to deny individual nurses' rights and responsibilities to develop their interests and abilities to their fullest potential, for the ultimate benefit of the health care consumer."

Alice Baumgart, dean of Queens University's School of Nursing, made note of this idea in a speech to the RNAO last year, and added that nurses need to support each other through informal networks to help build and reinforce professional identity.

It is clear then, for whatever reasons, that the blurred image of the nurse reflected in popular literature and television is perhaps a reflection of how nurses still see themselves — someone who is there, who can be molded into whatever the situation requires of her, but whose aims and personal goals may not always be apparent.

"Nursing is changing, and we can make it whatever we want it to be," Principal Nursing Officer Josephine Flaherty told nurses at CNA's Nursing Education Forum last year. Her words might serve as a guideline for nurses in the years to come: if it's an image change we want, we're the only ones who can do it. ♦

Jane Bock



# input

## Help for D.S. parents

As a nurse with a two-year-old foster Down's Syndrome child, I must commend The Canadian Nurse for publishing an up-to-date report on a syndrome surrounded by pre-conceived prejudices. I'm sorry it didn't appear sooner!

Living in a remote region of B.C., we have had to actively look for the support services and resources to help us care for the baby we've had since the age of three weeks. As recently as 1977, we were given information that emphasized the negative rather than the positive aspects of D.S.; his parents received little encouragement to keep him.

We heard about the Experimental Education Unit's work with Down's Syndrome at the University of Washington, Seattle and the information and

encouragement obtained from them has been invaluable; I would highly recommend contact with this model program for any new parent with a D.S. baby.

Our active two-year-old has developed into a curious little boy who is a pleasure to know and work with. Early education intervention does make a difference, and there is indeed a "new image" of Down's Syndrome.

*S. Coolbaugh, RN, Fernie, B.C.*

## Saints or sinners

It is with great pain and distress I read about the situation in Ontario ("You and the law" November); thank you for bringing it to my attention.

For me it epitomises the problem of hospital nursing — we the caregivers are

impotent "mops" for all the wrongs in the health care delivery system.

Any nurse who wishes to stay (in the hospital situation) in a so-called profession which prevents her/him from executing her/his trained beliefs and acquired related knowledge is either a masochist, a victim of sex role stereotyping or really into the "plug in for a paycheque" mentality.

I say to the I.C.U. nurses of Mount Sinai "right on" and to the Canadian Nurses Association "wake up now" to the parody of a profession. —*Helen L. Morgan, Victoria, B.C.*

## A labor of love

Midwifery has long been recognized as a specialized facet of nursing as evidenced through the additional studies, training and practice required. Employers, through specifications in their advertisements for staff, also recognize it. Yet the remuneration for such service, awarded by all of the major hospitals in this city, is a paltry \$2.15 per week on top of our regular salary.

Midwives in northern areas of our country, where doctors are not readily available, provide complete medical attention throughout the maternity cycle. In our high risk maternity case rooms, and in most delivery suites in Edmonton, the nurse/midwife supervises both normal and complicated labors; she institutes required preventive or remedial measures and, when the doctor is absent, acts in emergencies.

Our employment requires shift work and irregular days off, work hours that are only required of those providing emergency services.

Fortunately recompense is obtainable in the knowledge that we provide an essential service, in friendships formed with co-workers and in the acknowledgements of our

patients. The extra remuneration probably would not excite the newspaper delivery boy.

Perhaps the time has come for a concerted effort on our part. Are we over-emphasizing professionalism at the expense of obtaining recourse for our grievances?

—*Judy Rogers, RN, Edmonton, Alberta.*

## Realities of motherhood

I thought that readers of your audiovisual page might be interested in learning of a slide-tape presentation I produced last year during the International Year of the Child.

As an occupational therapist, I have worked with burned and battered babies and been saddened to see the anger and blame their young mothers are subjected to by medical and paramedical staff in hospitals. It is seldom anyone focuses on her as a desperate, lonely and neglected person.

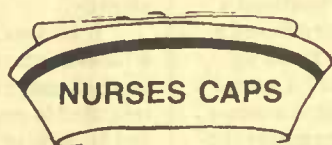
I wondered how to prevent this situation and, as a result, produced a photo-essay on the realities of motherhood which I have titled "Raising kids is hard: when you're alone it's harder."

The slide-tape presentation is intended primarily for unwed mothers who must decide whether or not to keep their baby. It is now being used by Terra, an association assisting unwed mothers, whose members helped me produce the slide-tape. The purchase price for the package is \$80 (including 100 slides, cassette and script); rental fee is \$12, plus \$4 for postage and insurance.

If your group wishes to buy a copy but lacks funds, might I suggest approaching a service club in your community such as Rotary or Kinsmen.

For more information, write: *Muffy Mathewson, BPT, OT Reg., 10322-132 Street, Edmonton, Alta., T5N 1Z1.*

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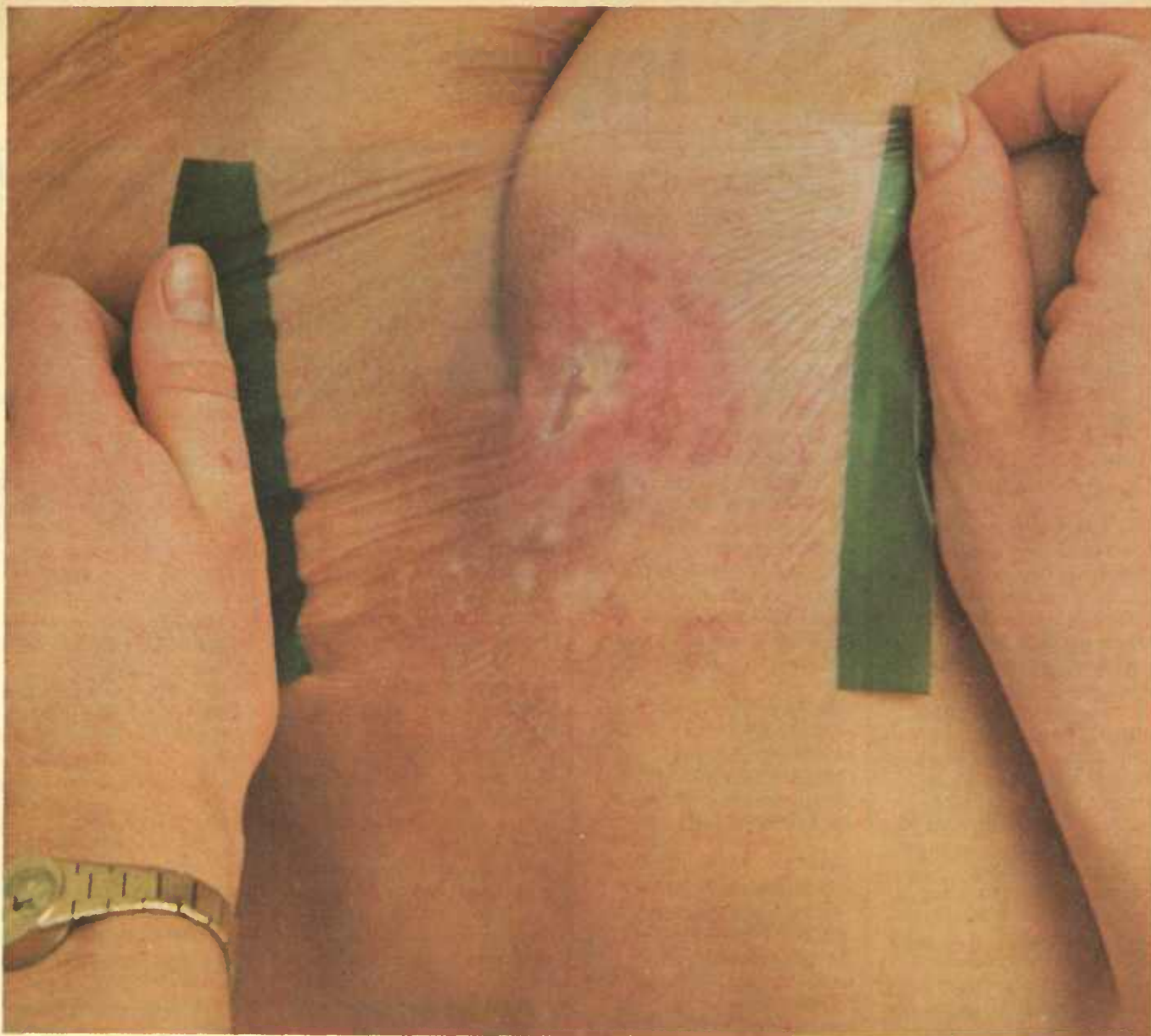
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# input

## U of A Postscript

I was very pleased to note the summary of university programs for RN's in the January issue, and would just like to add, for the record, that some courses taken at Athabasca University are transferable to The University of Alberta's Post-RN Program.

—Amy E. Zelmer, PhD, Dean, Faculty of Nursing.

## A non-traditional route

I sincerely hope that the person who compiled "Your guide to Post-RN University Programs in Canada" (January), did not intentionally disregard the many innovative and valuable certificate programs being offered to nurses by community colleges which are flexible and innovative enough to respond to the needs of Canadian nurses who are becoming more adamant in demanding post-RN educational opportunities specific to their specialized area of nursing.

I hope that a similar article in the near future can be done on college-based programs, or at least some form of recognition for what is being done in other than the traditional university programs (some of which haven't changed their content, faculty, or presentation format in twenty years).

I think that all nurse educators fully realized that university-based programs are more prestigious and of higher status than their "poor country" cousins, the colleges. I urge you to give equal space to some of the newly developing programs such as the Co-operative College Program For Occupational Health Nurses in the metro-Toronto area. Yes, even we in the West are involved in some new off-campus delivery programs such as the Occupational Health Nursing Certificate

Program offered by Grant MacEwan Community College in Edmonton and Calgary, and the Extended Care Program developed by the same college. The latter will soon be available to nurses on a distance delivery method which allows nurses who cannot attend lectures nine to five, Monday to Friday, to participate in post-RN education.

I look forward to articles that will dispel the myth that only universities offer post-RN education.

—Liz Dawson, RN, M.Ed., Program Head, Occupational Health Nursing Certificate Program, Grant MacEwan College, Edmonton, Alta.

**Editor's note:** A complete list of all the programs offered by community colleges across Canada would obviously be too vast an undertaking for our limited resources.

## Security is...

Jo Logan's article (January 1980) is both thought-provoking and mind-boggling. She tells nurses that they are handmaidens to other members of the health inter-disciplinary team — doctors, pharmacists, social workers, physiotherapists, occupational therapists and dieticians — because most of them do not have a university-based education.

She supports her position with a few personal examples. If anecdotes can lead to generalization, then I can safely state that nurses are far from being handmaidens. I myself have witnessed nurses telling other health professionals where to "get off" or "go and fly a kite".

If our insecurity is so intense and we keep telling ourselves that our salvation as a profession lies in a university degree, it will not be long before this insane, poorly documented notion becomes reality.

In all the years I have been a professional nurse, I have never heard a remark made to this effect by doctors or other members of the health team. What in God's name is wrong with nursing?

Nurses as a group of highly trained professionals are respected and they know it. I do not know of a single patient who has shown more respect to a particular nurse because she graduated from a university generic program. Again, no disrespect has been shown to a nurse by a patient because she has a diploma from a hospital-based or community college program. Nurses will be respected solely for the kind of care they give, knowledge they have and the attitude with which they care.

If nurses are handmaidens, then this also includes university-prepared nurses. Logan should explain to readers how university nurses have succeeded in not being handmaidens.

It may be that professional salvation lies in university preparation, but, as we are clamoring for scientific status, let us use some of that knowledge to support our belief.

—Mohamed H. Rajabally, RN, EdM, Lecturer, School of Health Education, Okanagan College, Kelowna, B.C.

## Career highlight

Scanning 1979 CNJ's, I came across the January issue with an article entitled "A New Role for the Psychiatric Nurse" by Kathy Hegadoren of Edmonton. Ms. Hegadoren states that the admittance of emotionally disturbed children to a general ward is an "experiment" and a "new role for the psychiatric nurse".

For your readers, I wish to state that in 1951-54, an almost identical project was instigated by child psychiatrist Dr. Gordon Stephens, M.D., at the Children's Hospital,

Winnipeg, and I was the psychiatric nurse.

In this position I observed and counselled children and parents; taught nurses and interns — both formally and informally; took social histories; recorded conferences; gave reports and home visits, and did much to change peoples' attitudes regarding the emotionally ill child and his needs.

This was the first attempt in Canada to have emotionally disturbed children treated in a hospital setting with a psychiatric nurse. We had a tremendous success story which, in retrospect, was the highlight of my nursing career. —Dorothy (Campbell) Mulder, RN, RPN, Part-time supervisor in Geriatrics, Beacon Hill Lodge, Winnipeg, Man.

## Kudo from afar

I would like to take the opportunity to say how much I enjoy reading *The Canadian Nurse*, and that it has proved to be most beneficial to me throughout my nursing courses. Thank you. —Tanya Mark, Holder, Australia.

## Nurses in primary care

There seems to be a rumor at large in the nursing community that McMaster's Educational Program for Nurses in Primary Care (Nurse Practitioner Program) has been discontinued.

I am pleased to deny the rumor and to confirm that the Ontario Ministry of Colleges and Universities, with the support of the Ministry of Health, has agreed to continue supporting the program for at least another year.

The program continues to receive strong support from the Faculty of Health Sciences, McMaster University.

—Mona Callin, Director, Educational Program for Nurses in Primary Care.



# news

## Prevention pays, PHN tells committee

In December 1979, a nurse-consultant in southern Ontario resigned from a committee set up to study ways to lower the death rate of premature and newborn babies. Her reason for quitting? The Medical Officer of Health in Toronto, where she was working, had refused to show her dissenting report to the provincial committee of which she was a member.

Doreen Hamilton, a nurse with degrees in sociology and education and varied experience in community health projects, had written a "minority" report for the committee showing that an education program for new mothers and teenage women would be effective in the city's goal of reducing the number of high risk pregnancies. The majority report submitted by the provincial committee, the University Teaching Hospitals Association and the Hospital Council of Metropolitan Toronto (UTHA HCMT) had recommended instead a central computer-based patient information registry and had also advocated improving neonatal intensive care facilities in Toronto. The cost of the proposed program was estimated at \$6 million a year; comprehensive education programs would cost about \$1 million.

Hamilton stated at the time that she felt the emphasis on high technology was an enormous waste of money and she favored the introduction of preventive programs. Also included in her plan were subsidized prenatal classes, genetic counseling studies of out-of-hospital birthing centers and the legalization of midwives.

Recently, CNJ spoke with Hamilton, who has since been rehired as a member of the Task Force for the Prevention of High Risk Pregnancies. She referred to

the Healthiest Babies Possible Program (see CNJ October 1979) which has been running in Vancouver and as an experiment in Toronto.

"That's the kind of program that's needed," she said, and she remarked that preventive programs with the emphasis on education reflected "a different attitude toward health care." In Ontario the Foundation for the Mentally Retarded recently sponsored an advertising campaign focusing on the effects of pregnant women's habits on unborn children, and she said the success of this campaign should serve as a lesson to professionals involved in public health. "We've tried selling beer on television and we know that works, why not sell health too?"

The controversy will not be resolved until after Hamilton and the new task force submit their report to the Toronto Board of Health at the end of April this year, but clearly the report will recommend preventive programs which will limit the number of high risk births rather than estimate and plan for a large number of high risk infants to be born in the city.

Asked for her views on nurses becoming more politically active and getting involved in the actual decision making in health care policies, Hamilton pointed out that this, while desirable, was difficult: "It's probably easier to do as a private person rather than as a nurse," she said. "As a nurse you're always working for somebody and you're not really free to say what you feel. For instance, I know that a large number of obstetrical nurses in this city are not comfortable with current obstetrical practices in the hospitals but they really have no choice."

The Task Force for the Prevention of High Risk Pregnancies plans a series of citizens' meetings in the City of Toronto this spring, and the health care professionals involved hope to find out

more about what consumers really want and expect from their health care system.

## CNF announces special scholarship

The Canadian Nurses Foundation has announced that it will name a nursing scholarship in memory of Virginia A. Lindabury, editor of *The Canadian Nurse* from 1965 to 1975, who died last September.

"Throughout her years with the magazine, she supported the foundation's purposes and goals in aid of nursing scholarship and helped make the work of the foundation known to nurses throughout Canada," Louise Tod, CNF president said in announcing the scholarship.

The Registered Nurses Association of British Columbia has supported the foundation's move with a \$10,000 donation in memory of Virginia; individual nurses across Canada have also expressed the wish to donate to a memorial fund in her honor.

CNF is the only Canadian foundation that deals exclusively with support to nursing scholars. Since its inception in 1962, 216 nurses have benefited from more than \$673,000 in funding. Moneys now come mainly from personal donations and bequests from individual nurses and from provincial nurses associations.

Tax deductible donations should be sent to the CNF, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

## Health happenings

Who decides the duties of a nurse working in an institutional setting? An Ontario Divisional Court has ruled that it is hospital management, rather than the College of Nurses, the licencing body in that province, that has the right to decide what these duties shall

be. The court has overruled an Ontario College of Nurses finding that the director of nursing at an Ottawa Hospital performed incompetently in directing RNA's to carry out certain functions previously reserved for registered nurses.

At stake is the key issue of whether a member of the management team (such as a director of nursing) is subject to discipline by the disciplinary body of that profession while acting in an administrative capacity and carrying out the duties attendant on the administrative function of that position.

Singer Della Reese will perform a benefit concert in London, Ontario, this Spring to raise funds for a new neuro-treatment microscope for University Hospital in that city. Reese is recovering from neurosurgery performed at University Hospital after she collapsed during a taping of Johnny Carson's "Tonight" show.

## A Bonus from RNABC

The RNABC has announced that funding is available to RNABC members to develop post-basic clinical nursing courses, or to study the need for such courses. To meet the association's requirements, a post-basic course must prepare nurses to function in clinical specialties which require expertise beyond the basic level.

At the time of writing, RNABC has provided funds for the development of three programs: in Occupational Health Nursing, Pediatric Nursing and Obstetrical Nursing. The association has budgeted \$100,000 for the total program, and up to \$5000 is available for each course.

For more information, contact Ruth Burstahler, Continuing Education Consultant, RNABC, 2130 W. 12th Ave., Vancouver, B.C., V6K 2N3.



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# news



Photo by Myron Rockett, University of Alberta

**Two-way closed circuit TV — the next best thing to being there?** A first for nursing is the course in advanced analysis of trends, issues and problems in nursing that Dr. Shirley Stinson of the University of Alberta is teaching simultaneously to two groups of students — one in Edmonton, the other 185 miles away at the University of Calgary.

There are 5 M.N. (Master's in Nursing) students in the Edmonton group and 6 graduate students (nurses taking a variety of master's degrees) in the Calgary group.

Each viewer group can see what is being transmitted from their studio, via two TV screens; through two additional screens they can see the other group via a "split screen", plus obtain close-ups on a second screen. Even visual aids as small as the title of a book and "blackboard-type" writing on the flipchart are readable on the close-up screens.

Simultaneous visual and audio transmission between Edmonton and Calgary is via microwave. A direct phone line is also available in the TV studios and all transmission is as confidential as a phone call.

## Occupational health nurses receive \$95,000

The Ontario Occupational Health Nurses Association is \$95,000 richer after receiving a grant from the Ministry of Labor for the development of a certification program for occupational health nurses in that province.

The award, out of the Ministry's Provincial Lottery Funds for Manpower Training and Development, will be used to develop the various program components. Target date for implementation will be January, 1982.

"Occupational health nurses have, through their initiative and commitment, been granted both an opportunity and a challenge; they can be justifiably proud of this expression of confidence." OOHNA president Madeleine Wenman, commented, "This

is a tangible recognition of their efforts to expand their contribution toward the goal of reducing the incidence of injuries and illnesses in the workplace."

## Nurse-midwives solicit members

The Western Nurse Midwives Association has announced their executive for 1980: president is Peggy Anne Field of Edmonton, president-elect is Carolyn Fumalle of Victoria, B.C., and the secretary-treasurer is Margaret McKenzie of Edmonton.

The association is actively canvassing for new members this year, and invites inquiries to be sent to the Association at P.O. Box 4268, Edmonton, Alberta, T6E 4T3. The membership committee chairman is Judy Friend of Edmonton. ♡



# calendar

## March

**The Confectionery Manufacturers Association of Canada** is sponsoring a one-day invitational seminar on nutrition, including such topics as the role of nutrition in competitive sports, new perspectives on nutrition and health disorders, the psychology of eating and the snacking syndrome. To be held March 10 at the Four Seasons Hotel in Toronto. Contact: *Jane Hope, Suite 101, 1185 Eglinton Ave. E., Don Mills, Ontario, M3C 3C6.*

**Continuing Nursing Education** focusing on Nursing and Geriatrics, a seminar, will be held March 26 at McMaster University. Contact: *Patricia Carter, Program Assistant, Program in Continuing Medical Education, Room 1M6, McMaster University, Health Sciences Center, Hamilton, Ontario, L8S 4J9.*

**The Shifting Medical Paradigm: From Disease Prevention to Health Promotion**, a conference for health professionals, planners and consumer advocates, will be held March 20-21. Contact: *Lifestyles Programs, Centre for Continuing Education, 5997 Iona Drive, The University of British Columbia Campus, Vancouver, B.C., V6T 2A4.*

**The Faculty of Nursing and Extension of the University of Alberta** is offering the following courses: Teacher Effectiveness in Nursing, Feb. 28-29; Nursing Aspects of Intravenous Therapy, March 26 or May 5; Management of Inflammatory Bowel Disease, April TBA; Advanced Obstetrics, April 21-25; Nursing Management of Pain, May 16; Introduction to E.C.G. Interpretation, June TBA. Contact: *Marg Steed, Director, Continuing Nursing Education, Faculty of Extension, The University of Alberta, Corbett Hall, Edmonton, Alberta, T6G 2G4.*

**The CNA Audited Financial Statements**, which normally appear in the March issue of this journal, have been dropped from the 1980 publication as an economy measure. The statements will, as usual, be included in the association's annual meeting and convention report available to registrants at CNA's annual meeting in Vancouver, June 22 to 25. In addition, members wishing to receive a copy of the statements may write to CNA, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

## April

**Respiratory Rehabilitation in the Eighties** is a seminar sponsored by the York-Toronto Lung Association on April 2 at the Royal York Hotel. Pre-register by March 3. Contact: *Nancy Blackburn, York-Toronto Lung Association, 157 Willowdale Ave., Willowdale, Ontario, M2N 4Y7.*

**Clinical Electrocardiology** with Leo Schamroth, M.D., a workshop for general practitioners and critical care nurses will be held on April 10-11, Dartmouth Inn, Dartmouth, N.S.; April 14-15, Park Plaza Hotel, Toronto, Ontario; and April 21-22, Four Seasons Hotel, Vancouver, B.C. Contact: *Conference & Seminar Services, Humber College, P.O. Box 1900, Rexdale, Ontario, M9W 5L7.*

**The North West Territories Registered Nurses Association** will hold its third biennial meeting April 16-18 in Yellowknife. The theme will be "Legal Aspects of Nursing". Contact: *Rusty Stewart, Secretary, NWTRNA, Box 2757, Yellowknife, N.W.T., X0E 1H0.*

**The Head Injured Patient**, a workshop presented by the Canadian Association of Neurological and Neurosurgical Nurses - Manitoba Chapter, will be held April 15-16. Contact: *The Manitoba Association of Registered Nurses, 647 Broadway Ave., Winnipeg, Manitoba, R3C 0X2.*

**An Extended Care Nursing Certificate Program** designed to prepare registered nurses to provide quality care to the aged, disabled and chronically ill, will be available by spring, 1980. Nurses may complete modules at home by means of individualized study packages. If you are interested in the program contact: *June Golberg, Acting Program Head, Extended Care Nursing Certificate Program, Grant MacEwan Community College, Box 1796, Edmonton, Alberta, 4*

Canadian Nurses Association  
annual meeting  
and convention

**Get ready, Get set, GO**  
Vancouver, June 22-25, 1980



### Late news flash

### Israeli Nursing Leader To Deliver Kellogg Lecture

Dr. Lea Zwanger, head of the Division of Allied Health Professions in the Ministry of Health, Tel Aviv, Israel, has agreed to deliver The Kellogg Lectureship scheduled for the opening day of this year's CNA convention.

Dr. Zwanger's address will focus on the nurse's role in delivering primary care, a role that may be seen as a solution to one of society's current and emerging problems in the area of health and the spiralling costs of health care in Canada.

In accepting the invitation, Dr. Zwanger said: "Primary Health Care - Nursing, is one of my major educational and service interests. The statements you provided about CNA's beliefs fit my own convictions. Therefore, I hope that my presentation will reinforce those of CNA."

Dr. Zwanger who was born in Jerusalem received her Diploma, Graduate Nurse from Henrietta-Szold Hadassah School of Nursing. She earned her B.Sc., MA and EdD from Columbia University, Teacher's College in New York City.

## PROGRAM HIGHLIGHTS

### Sunday

- Kellogg Lectureship: "Primary care—nursing"
  - Wine and cheese reception.
- Your host: RNABC

### Monday

- Keynote address: "Who shapes nursing in the 80's?" Lorine Besel, Royal Victoria Hospital, Montreal.
- Panel presentation: "Financing health care"
- Meet your candidates

### Tuesday

- Panel discussion: "Labor movement vis à vis the professional association"
- Dinner and entertainment

### Wednesday

- Debate: "Continuing education: should it be voluntary or mandatory?"



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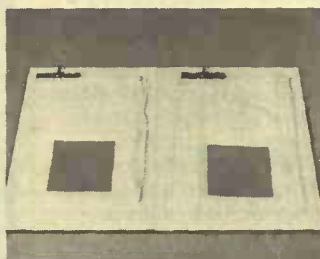
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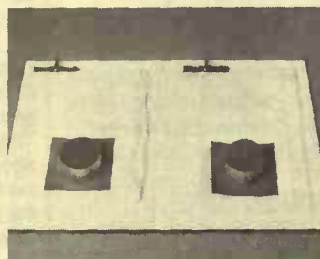
Cloth

Pampers

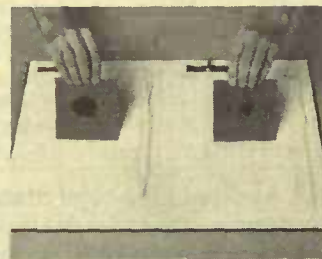
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# YOU AND THE LAW

## Consent, sterilization and mental incompetence: the case of "Eve"

Corinne Sklar



Fearing that her 24-year-old, physically mature, potentially sexually active, mentally retarded daughter, "Eve", might become pregnant, Mrs. E. applied to the Court for authorization of consent to the performance of a tubal ligation on her daughter. Her application was denied<sup>1</sup> but the reasons for the denial are at least as important as the outcome since the decision champions the interests of the individual unable to make the decision himself to undergo such a procedure. The observations of the P.E.I. Supreme Court (Family Division) judge who heard the case, Mr. Justice C. R. McQuaid, are noteworthy for their sensitive and careful examination of the issues, rights and concerns of both mother and daughter.

The area of sexual activity is of major concern to those responsible for the care and well-being of the mentally retarded. Unfortunately, the topic generally becomes charged with an overlay of individual emotional responses; similar responses may be precipitated when teenage sexual activity is under discussion.<sup>2</sup> Although there is considerable mythology and misinformation about the sexuality and fertility of the mentally retarded and the potential transmission of genetic defects to their offspring, there is in fact the practical problem of what, if any, contraceptive measures can be provided for such a sexually active individual. In many cases, traditional methods of contraception (oral contraceptives, I.U.D., foams and creams, etc.) are only as effective as the user's adherence to the method selected. Sometimes, complete supervision of the individual is necessary to ensure that the method selected is effective. Because the usual contraceptive methods may be ineffective for retardates, sterilization may be viewed as the major viable alternative. Such an approach is indeed not surprising in a society where vasectomies and tubal ligations are frequently sought by competent Canadian adults in consultation with their physicians.

Note, however, the use of the key word "sought": the individual seeks and consents to the performance of this surgical procedure upon his or her body. In the case of "Eve" and others like her, this ability to give such consent may be lacking. Can others give consent to such a procedure on this person's behalf? How do we balance the interests and rights of this individual against those of society or against the concerns of the individual's family?

It is a cardinal principle of the law that the adult individual has the right to control his body from invasion and interference by others: failure to respect this individual right may result in the commission of the legal wrong of battery. If the individual consents to interference with his body, then the tort (or wrong) of battery is not committed. Similarly, if there is legal justification for the touching (such as in a health- or life-threatening emergency), then no wrong is committed. Thus for those delivering health care, consent or other legal justification are necessary prerequisites to commencing treatment. This consent may be expressly given or it may be implied but always, in order for it to be legally valid, the following requisites must be present:<sup>3</sup>

- The consent must be voluntary, freely given and must be obtained without misrepresentation or fraud.
- The act performed must be relatively consistent with the act for which the consent was obtained.
- The act for which the consent is obtained must not in itself be an illegal act.
- The consent must be informed: the patient must be given sufficient information regarding the nature and consequences of the proposed treatment to permit the patient to come to a reasoned decision whether to accept or reject the treatment.
- Finally, to give consent the patient must have the legal capacity to do so (capacity referring to both age and mental competence).

Traditionally, it is the mentally competent adult who may give consent to treatment. Adulthood is attained at age 21 (common law age) or at the age of majority (18 or 19 depending on the specific provincial legislation applicable). In the area of medical treatment, some provinces have enacted

legislation which further lowers the age of consent, thereby enabling minors (those under 18 or 19) to give consent to medical treatment. Thus, for example, in British Columbia and New Brunswick, under certain conditions, a minor of 16 may give consent to medical treatment.<sup>4</sup>

It is the second aspect of the prerequisite of capacity that is of concern here: mental competence. The law requires that an individual must have the ability to understand the nature and effect of the treatment being proposed. If this ability is lacking either by reason of age, immaturity or illness or other mental disability, then those providing health care must look to others for such consent. At common law, the persons having authority to give such consent are a parent, guardian or the Supreme Court. The law imposes another safeguard to protect the person who is unable to give consent on his own behalf: the procedure in question must be therapeutic, that is, for the benefit of the incompetent individual.

The person wishing to provide consent for the incompetent individual must attempt to place himself in the position of that person and arrive at the decision that person would have made if able to do so. While almost impossible to do with any high degree of certainty, nevertheless, this imposes upon the substitute decision-maker the responsibility of acting in the best interests of the incompetent person. In the case of "Eve", the parent asked the Court to authorize her consent to her daughter's sterilization as a contraceptive measure. The Court followed the trend of judicial determination and examined the proposed procedure in the light of its inherent benefit to the individual "Eve". Since there is no specific legislative authority permitting such sterilization, it was held that sterilization of a mentally incompetent person solely for the purpose of contraception is not a therapeutic procedure justifying the Court's authorization of the consent of another to its performance.

### The case of "Eve"

Eve (a pseudonym designated by the Court) is moderately retarded. The Court was told that she is an individual "having some limited learning skills". She suffers from extreme expressive aphasia, making her unable to



communicate to others any thoughts or concepts she might perceive inwardly. No one knows, therefore, whether Eve has inwardly perceived a thought or concept, nor her degree of understanding of this idea or concept. The retardation further compounds this difficulty.

Eve attends a school for retarded adults during the week and lives at home with her mother on weekends. Her mother, Mrs. E., is a widow, nearing 60 years of age. At school, Eve developed a close relationship with another student, a young man. On being informed of this situation, Mrs. E. became concerned that Eve could become pregnant and that she would therefore have the responsibility of any child born to her daughter. At Mrs. E.'s age, and in her circumstances, such a responsibility would present overwhelming difficulty. Thus, Mrs. E. instituted this application to the Court. In considering these facts the Court was sympathetic to the bona fide concerns of this mother for the well-being of her daughter and the potentially harmful emotional effects of a pregnancy and subsequent birth upon Eve. Eve would have no concept of either the idea of marriage or of the cause and effect relationship between sexual activity, pregnancy and birth. While Eve might be able to care for a child under close supervision, she would have no concept of motherhood other than in a mechanical sense.

Before considering the legal principles involved, Mr. Justice McQuaid examined specific evidence and concluded that Eve was incapable of providing informed consent and would be unable to undertake effective alternate means of birth control. It was also established that the psychological effect upon Eve of such a procedure would probably be minimal.

The decision reviewed the basic legal principles regarding consent to medical treatment, the judge indicating the "gray area" surrounding the question of consent on behalf of a mentally incompetent individual. While valid substitute consent could be given for a strictly therapeutic procedure on behalf of the retardate (e.g. consent for an appendectomy), the nature of this proposed treatment demanded stringent consideration.

His Lordship quoted from the case of *Murray v. McMurchy*:<sup>5</sup> (In that case, while delivering a young woman by Cesarean section, the physician observed fibroid tumors in the patient's uterus and proceeded to tie off her Fallopian tubes. Because there was no evidence of emergency in the situation, the Court held that such a drastic procedure should not have been undertaken without prior discussion with and the consent of the patient. The doctor was found liable for exceeding the patient's consent.)

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"It must be remembered that the effect of the procedure here was to deprive the plaintiff of the possible fulfillment of one of the greatest powers and privileges of her life."

His Lordship stressed the scrupulous caution that must be taken before similarly depriving Eve even though she might not be able to understand and fully appreciate that fulfillment and privilege.<sup>6</sup>

On consideration of the legality in general of sterilization for contraceptive purposes, His Lordship concluded that such sterilization is not illegal if the patient voluntarily agrees to the

procedure, if the consent is informed and if there is found a benefit to the patient having regard to either the patient's health or to other justifiable reasons, eg. socio-economic factors.<sup>7</sup> While such surgery may be necessary to preserve or protect life or health, it may also be legally undertaken to preserve the quality of life of the patient. This was the result in *Cataford v. Moreau*,<sup>8</sup> a case in which the plaintiff sued when the tubal ligation performed after the birth of her tenth child was faulty and she subsequently delivered an eleventh child. However, Mr. Justice McQuaid cautioned that purely contraceptive

sterilization, even with consent, may not necessarily be legal in all situations. As always, the facts of each case are determinative.

The permanence of this non-therapeutic procedure was the major concern of His Lordship. He considered the English case of *Re D (a Minor)*. D was a retarded child suffering from Sotos Syndrome. Her parents had decided to have her sterilized at age 18 to prevent her having children who might also be so afflicted. Their family physician concurred in their views. When D reached puberty at age 10, the family sought to have her sterilized at once. The Court denied the application, stating that sterilization involves the deprivation of a woman's basic human right, the right to reproduce, and performance of such a procedure for non-therapeutic reasons without her consent would constitute a violation of that right. In that case, the evidence was that while D presently was unable to appreciate the nature and consequences of this procedure because of her age (11 years), there was a strong likelihood that she would be able to understand its implications when she reached 18. The Court refused to deny her the opportunity and right to make this choice on her own behalf in later years. The Court further stated that any decision to undergo surgical sterilization for non-therapeutic purposes was not solely within the clinical judgment of a physician.<sup>9</sup> Here Mr. Justice McQuaid found that the test of the therapeutic benefit of such a procedure is neither the subjective view of parents nor the clinical judgment of a physician. An objective position with regard to benefit must be taken.

In the case of Eve, the request for court authorization of the consent invoked the traditional jurisdiction of the Court as *parens patriae*, that protective responsibility toward the Queen's subjects (i.e. the State) which is delegated to the Courts by the State. This protection is given to those who are unable to take care of themselves and is exercised where injury has occurred or where there exists a likelihood of harm occurring. His Lordship quoted from the words of Lord Eldon in 1827:

"...and it has always been the principle of this Court not to risk the incurring of damage to children which it cannot repair, but rather to prevent the damage from being done..."<sup>10</sup>

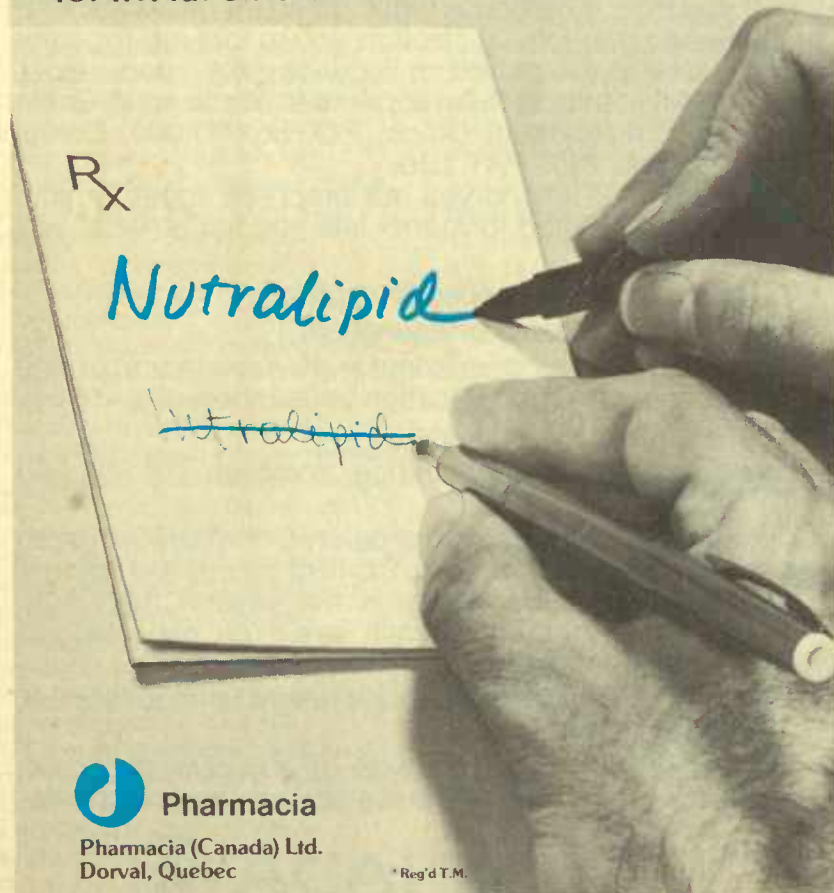
Because of the irreversible nature of sterilization, the denial to Eve of her fundamental human rights, and the possibility of future medical remedy for Eve, His Lordship concluded that the Court did not have the authority or jurisdiction to authorize a surgical procedure such as sterilization for purely


(Continued on page 52)

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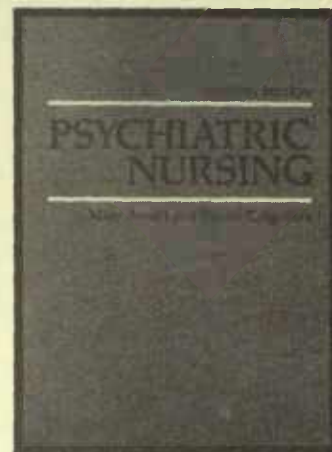
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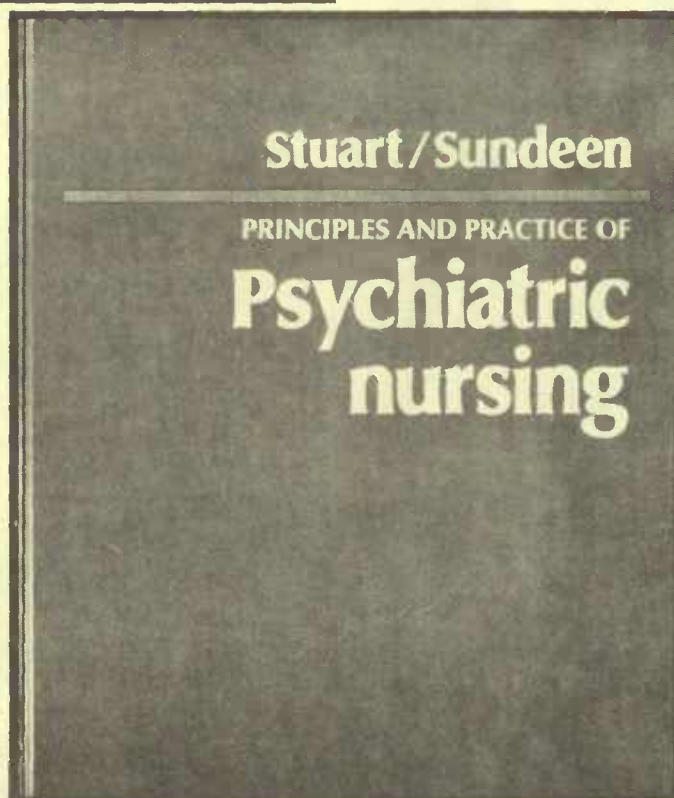


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# Community health care and the nursing process

Margot Joan Fromer

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# A capsule history of your journal

*"The need to communicate has been the motivating force behind the development of newspapers, magazines and journals of all types. Depending on the nature of the information to be communicated, the publication may become specialized and develop specific aims but the simple hunger of the people to know what others with similar interests are doing is always the underlying if unspoken raison d'être."*

Margaret E. Kerr, editor *The Canadian Nurse*

**1905** — The first, 32-page issue of *The Canadian Nurse* appears, largely at the instigation of **Mary Agnes Snively**, Toronto General Hospital superintendent of nurses. Sponsored by the TGH alumnae, the operation is in the hands of a business firm, Commercial Press. A member of the medical profession, **Dr. Helen McMurchy**, is chosen to act as editor on a part-time basis, a move calculated to deflect criticism being voiced by doctors who were "at a loss to understand this show of independent thinking". Journal policy is governed by an editorial board composed entirely of nurses and a registered nurse, M. Christie, is named business manager.

**1907** — *The Canadian Nurse* goes monthly.

**1910** — In May, **Bella Crosby**, a graduate nurse, is appointed associate editor part-time of *The Canadian Nurse*. Crosby

begins to meet with nurses throughout Ontario and in Montreal to stress the national character of the journal and solicit support.

**1916** — *The Canadian Nurse* is purchased by the Canadian National Association of Trained Nurses (later to become the Canadian Nurses Association). The editor of the journal is **Helen Randall**, a graduate of the Royal Victoria Hospital in Montreal. Subscribers now number 1,800.

**1924** — Randall resigns, with the subscription list at 1,950. **Jean S. Wilson** becomes executive director of CNA and editor of *The Canadian Nurse*.

**1932** — CNA headquarters moves to Montreal from Winnipeg.

## The Canadian Nurse

A QUARTERLY JOURNAL FOR THE NURSING PROFESSION IN CANADA

VOL. I. TORONTO, MARCH, 1905. No. 1

THE CANADIAN NURSE will be devoted to the interests of the nursing profession in Canada. It is the hope of its founders that this magazine may aid in uniting and uplifting the profession and in keeping alive that *esprit de corps* and desire to grow better and wiser in work and life which should always remain to us a daily ideal.

For the protection of the public and for the improvement of the profession THE CANADIAN NURSE will advocate legislation to enable properly qualified nurses to be registered by law.

Vol.1, No.1, The Canadian Nurse,  
March, 1905.



**Mary Agnes Snively**  
Lady superintendent, Toronto General Hospital



**1933** — Ethel Johns of the Winnipeg General Hospital is appointed editor and business manager of *The Canadian Nurse*, the first full-time appointment to this position. Johns' concern is with ways to increase subscriptions. She makes changes in the format of the journal and improvements in advertising contracts.

**1944** - Johns retires; the mailing list stands at 5,000 subscribers. Margaret E. Kerr becomes editor, a position she will hold for 21 years.

**1946** — At least one article and all releases from the National Office, are to be in the French language for every issue of the journal.

**1949** — Kerr begins her campaign for subscription through association fees.

**1950** — NBARN becomes the first provincial association to accept a plan to include journal subscriptions in the annual registration or licensing fee paid by members. Other provinces follow New Brunswick's lead.

**1955** — Journal staff is increased to include its first full-time assistant editor, a circulation manager and advertising manager.

**1958** — Kerr's title is changed to executive director and editor of the journal. Editorial advisors are appointed, with each province appointing one member (two from Quebec).

**1959** — In June, the first issue of *L'infirmière canadienne* is published. The mailing list stands at:  
English: 48,797 subscribers  
French: 7,958 subscribers.

**1965** — The journal is reaching 113 countries outside Canada. Margaret Kerr resigns as editor. The number of subscriptions has risen to 59,985 (English) and 14,196 (French).

**1966** — On April 1, the entire CNA operation is centralized in the new CNA House in Ottawa.

**1975** — In August, Virginia A. Lindabury, editor of *The Canadian Nurse* for the past ten years, resigns, to be succeeded by the present editor.

**1979** — In September, official count puts combined circulation of *The Canadian Nurse* and *L'infirmière canadienne* at 132,989. A total of 88,865 nurses in Canada receive copies of the English edition of the journal. Close to 2,000 copies are distributed in the U.S. and abroad. ♣

## input

To the Editor Canadian Nurse.

There have been cases where sickness has come suddenly in the early part of the day and the servant has left, "bag and baggage" before the nurse could arrive. Other cases also occur, where the servant engaged to go to a home, suspecting the mistress of becoming a mother soon, will simply never even let the mistress know she doesn't intend to fill her engagement. These cases make the nurse see the varied conditions of work, and she has to be always on the alert for such emergencies. Consequently a nurse must be a capable housekeeper, cook, companion, dishwasher, a general "factotum"; also giving the requisite amount of attention her patient demands, besides keeping an eye on any children there may be and seeing they get off to school and are behaving properly.

All this seems a tremendous amount of work not called for by the "nursing code" but it *has* to be done in the West for the majority of patients are not in a position to

keep more than one maid of all work and often not that, and *true woman cannot and will not* see a "home" suffer for lack of a few extra hours' work. When a nurse goes out of the city on a case, she finds still another kind of life. There are no conveniences in the farm house, as a rule, and if it is in the winter time she has to melt ice for water and will often have to do the necessary washing to keep things going until the farmer can get help, but I must say the western farmer is as good as a woman in the house and can keep house, cook meals, and do a hundred things that would be like "Greek" to an easterner.

A Winnipeg Nurse

What is the solution?

Will some one give information regarding the system carried out by the Toronto Registry as to the payments for nursing cases, where full fees cannot be charged? There are quite a number of patients who are unable to pay the regular charge, but who prefer to be nursed in their own homes instead of going to the hospital, and could afford a

graduate nurse providing the charges were moderate. I am speaking of the West, where there are so many young couples and small families starting in life, where the charge of \$18 a week is a terrible drawback, and yet where the patient could pay a smaller amount and not feel under a charity obligation. Of course, I know many of the nurses charge \$18 for the first week and give their services free for say two weeks more, but that again places the patient in the "pauper class". Then, there are some nurses who take a note of hand with interest for the full amount, and it takes years to pay it. Surely there must be some solution to the problem of the wage-earning class to employ graduate nurses and satisfy both sides. If there is not would it not be better for the graduates to study this class of patient and solve the problem of the employment of "untrained or in experienced nurses, because their charges are lower?"

Dear Madam, — Our Training School is yet in its infancy, and has had difficulties to overcome incidental to most

beginnings, but promises to do well. The term of training is for three years, the age limit 21 to 30. Candidates come for a month on trial, which may be extended, and, if necessary, they sign an agreement for three years. Our present staff consists of sixteen nurses, which number will be doubled when the new wing now in contemplation will be finished.

We do not take infectious cases, but there is a hospital for infectious diseases just finished and standing in the same grounds, to which we hope to send our nurses for special training.

We have an X ray department and a Finsen light for the treatment of lupus cases. We get a great variety of surgical cases, and our operating theatre is used daily. Being the only hospital for the whole island, we have to refuse cases constantly that ought to be admitted, and our number of patients always equals the number of beds. With kind regards, Believe me, yours sincerely,

M. Southcott, Supt. of Nurses.  
General Hospital, St. John's,  
Newfoundland. ♣



# books

**AILMENTS OF WOMEN AND GIRLS.** By Florence Stacpoole. (Bristol: John Wright & Co.) 2s.

"Suffering is not woman's necessary lot." These true and simple words are the keynote of this book. It is not a book for children, but for mothers and aunts and others who are, or ought to be, grown-up. The author is well known as a lecturer for the National Health Society and for the Councils of Technical Education, and in this book she has stated in clear and suitable language the principal physiological facts which women especially ought to know, and the usual causes of various ailments from which many women suffer. We have often wished for such a book, and there are many women to whom it would be a help. There is in the preface a necessary caution against any attempt at self-treatment.

**SIMPLE LESSONS ON HEALTH, FOR THE USE OF THE YOUNG.** By Sir Michael Foster, K.C.B., M.P. (London: Macmillan & Co.) 1s.

From his home at Ninewells, in England, one of the greatest men of the age writes a preface to a little book on health he has prepared for the use of children in which he tells how he came to write it. There are four chapters — Fresh Air, Food and Drink, Light, Cleanliness—simple with the simplicity characteristic of a great mind. This primer is a model, and we can only thank the "distinguished friend" who induced Sir Michael to write it, by objecting to his "destructive criticism".

(Vol.1, No.4, December, 1905).



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## Nursing practice



**"Some makeshifts", Vol.2, No.2, June, 1906.**

**Preparation of Room.** — Sometimes an operation has to be performed in a room whose walls are covered with a dirty wall paper which cannot be washed, and which, if swept, would probably send out into the air thousands and legions of bacilli and cocci to infect the wound. To prevent the dust from flying fill the room with steam, by putting into it pans or tubs of hot water, and dropping into them bricks, almost red hot, this will send out clouds of steam. Shut the door at once and keep it closed as long as possible. Papers spread upon the floor and pinned or tacked down will, if there is a carpet which cannot possibly be taken up, prevent the carpet from being soiled, and the dust and infection, lodging in the carpet, from being stirred up by the feet.

**"A short historical retrospect, Montreal General Hospital", Vol.2, No.1, March, 1906.**

Perhaps the great difference that would strike a stranger on entering the hospital would be the size of the wards and the neatness with which they are kept by that modern institution, the trained nurse. In my early student days the wards were all small, none holding more than a dozen beds, and most much less, and the nurses — or Sarah Gamps — I cannot describe them! Some were good creatures and motherly bodies, all uneducated, but mostly kind — which was considered a great desideratum.

The day nurses were fairly good, but the night nurses were as a rule untrustworthy. One nurse attended to three flats, and she often appropriated to herself the stimulants deemed necessary to support some sinking patient, and if a patient was obstreperous he was strapped down hand and foot to his bed.

How different is the conduct of the ward now and how carefully each patient is guarded and cared for, and how strictly our most minute orders are carried out by our most zealous and intelligent staff of nurses.

Now the operating room is presided over by a nurse who knows more about asepsis than the surgeon, who is deeply versed in all kinds of instruments and their uses, and who knows how to prepare sutures and ligatures, dressings and bandages, lotions and antiseptic paints, so that germs have no place in her kingdom, but are driven out by her coadjutor angel, Heat, whose fiery sword does not drive them to the bottomless pit, but destroys them utterly.

**"Our responsibility re Tuberculosis", Vol.2, No.1, March, 1906.**

The great battle of the twentieth century against tuberculosis demands the help of every trained nurse. The average nurse has very little opportunity for studying phthisis in its incipient stage owing to restrictions in many hospitals against accepting tuberculous cases, and generally regards a consumptive as an emaciated, coughing, and hopelessly ill patient.

Nurses must fully comprehend a few leading facts about consumption. The person suffering with tuberculosis may not be a "patient". He may be a visitor to the family, or one of the household who "has a cold that he cannot shake off," or who "seems to have a slight cough, but does not think anything of it," or who is "run down and has indigestion and feels lazy all the time."

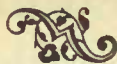
Let the nurse be ready to speak quietly but firmly and tactfully to the one who has aroused her attention, and urge him to see his physician, pointing out that serious lung trouble may sometimes first manifest itself in that way. If this were done throughout the country surely many and many a man or woman, acting on the trained nurse's suggestion, would consult his medical adviser and his disease would be discovered before his chance of recovery was gone.

**"Count the forceps", Vol.1, No.3, September, 1905.**

On June 1st, 1902, a patient was admitted to be operated on for an ovarian cyst. The patient was a woman weighing one hundred and seventy pounds, and there were many adhesions. Sutures were removed on the seventh day, and patient went home on the twenty-first day. During the next two years the patient lost flesh rapidly, was troubled with constant diarrhea, and had different medical men to attend her, but without relief. On June 4th, 1905, patient passed, per rectum, one handle of an artery forceps, and on the following week was brought to the hospital, where a second incision was made and the other part of the forceps removed from the intestine. Patient improved for two days, then died of post-operative peritonitis.

Some people severely criticize the nurses for not counting the forceps. There were four doctors present. Forceps are now counted in this hospital.





Volumes could be written on the question of prevention of waste in hospitals, and many of us could contribute from our own practical experience and observation what would help to lessen the expenditure, especially for food. Some hospitals dispose of their food garbage to contractors for stipulated sums.

In one hospital at least in Canada, where the white of the egg only is required for making drinks, the yolk is consigned to the garbage pail. Waste — willful waste. The yolks should be put in water and sent daily to the kitchen where they could be used in the making of puddings, cakes, salads, omelets, etc.

Waste, breakage, misappropriation. How can these conditions be remedied or improved? No amount of worrying or scolding will improve matters — but if the value is known, then responsibility and economy will be practised.



In our little training school of ten pupil nurses we have an admirable course of lectures, extending over eight months of each year, and on the following subjects: Anatomy and physiology, 12; materia medica and therapeutics, 6; hygiene, toxicology and medicine, 9; surgery, 6; gynecology, 4; obstetrics, 6, and urinary analysis, 4.

With one lecture a week, it is obvious that these cannot all be given in one session; so my plan is to have them cover two years. One evening each week is devoted to class work with the Superintendent, where the Public School Anatomy and Physiology, with Hampton's "Nursing", are the text-books. This is also the time for talks on ethics, hospital etiquette and kindred subjects. I begin each session with the younger nurses, but all attend except the senior, who relieve during class. Then on lecture night the juniors relieve, and all the second and third-year nurses attend. One evening each week is thus devoted to class work, and one to lectures. I find this plan works out very well.

We have a diet kitchen, but I regret that I have not yet been able to arrange for any special instruction in dietetics.

From an Ontario Hospital, "The Contributors' Club", Vol.1, No.3, September, 1905. 4

# news

During the early part of April Winnipeg suffered from a street car strike which, for a week, tied up the service, and was decidedly inconvenient for the District Nurses and the Victorian Order Nurse. The only satisfaction they got out of it was the fact that the men cheered them and encouraged them "to walk", which was really hard work, as Winnipeg covers an immense area.

The Secretary of War, Mr. Haldane, has been asked in the House of Commons why military nurses should not be allowed to go to dances. Mr. Haldane explained the evil effects of late hours. Nurses have been expressing themselves in their own paper to the effect that the discussion was unnecessary, as no good nurse on duty wants to go to balls.

The Training School for Nurses in connection with the Hospital for the Insane at Brockville, has closed its first year with gratifying success. Arrangements have been made to have the examinations conducted uniformly with the Asylum Nurses' Branch of the British Medico-Psychological Association, so that graduate nurses will be recognized as members of the British Association. This arrangement will likely be very satisfactory, and the Brockville institution deserves credit for taking the lead in Ontario in securing recognition to Canadian nurses who train in this special work of nursing mental and nervous cases.

## Did you know?

During the past year no less than 39,223 patients were treated in the hospitals of Ontario? There are now 64 public hospitals in Ontario

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## Professional Image

Trained nurses are regarded by the public with very mixed feelings. As a class their position, and the good they do in the hospital is now unquestioned, although individuals may be prejudiced against some particular nurse and her ways. But outside the hospital the trained nurse is still regarded as a not altogether unmixed blessing, and the public will need several more years of education — in which, perhaps, proper legislation by which the standard requirements for members of the profession will be more precisely defined, will be of no little assistance — before they can be brought to thoroughly appreciate her position or the relative value of the services of the trained nurse, and those of the untrained attendant and the well-meaning, enthusiastic, but untaught amateur.

And after years of toil, after nurses as individuals, and as a united profession have shown themselves to be necessary for the public welfare, it will most assuredly come about that more and more people will come to the conclusion that capability in nursing does not come by chance, and that a natural liking must be supplemented by education and practical training; they will gradually appreciate the fact that a trained nurse has spent time, money and much physical effort in acquiring her education, that the mental and physical strain of the work are more arduous than perhaps any other kind of work done by women, and, therefore, that this expenditure deserves suitable recognition at their hands. 4



# A little crystal ball gazing

Nursing in the year 2000 — what will it be like? To find out, CNJ asked some of today's nurses to do a little crystal ball gazing and let us in on what they saw.

**Helen Taylor**, president of CNA for the past two years and director of nursing at Montreal General Hospital, sees nursing as changing in response to societal pressures: "In keeping with the belief that health is a fundamental human right and that every person should have access to a complete range of health services and social services from the cradle to the grave, nurses will be expected to assume increased responsibilities as our health care structures change to meet these goals. These responsibilities will include more primary care settings in which nurses provide management of therapeutic regimens, education and counseling.

"Nurses will also be expected to take more responsibility for coordinating care, for promoting the continuity of care and for intervening in crises situations. As more nurses move into a greater variety of settings — family practice settings both inside and outside of hospitals, group practice centers, occupational health programs — they will become more independent and will be directly involved in complex decision making. Nurses will become more innovative and creative as they learn community skills such as consultation, community organization, convening of various service networks, monitoring environments and collecting and communicating feedback information. The nurse epidemiologist will carve out a special role for herself.

"As our youth-centered society becomes more adult-oriented, attention will focus more on the needs of the aged and chronically ill. Emphasis on acute illness and efficiency will lessen and more of our efforts will be directed to control instead of cure, to management rather than total recovery. By the year 2000, the special nursing skills required for care of the elderly and the dying will be more fully appreciated."

Taylor predicts an expanded role for nurses at all levels of the health care system: "They will be planners, administrators, specialists, generalist practitioners, teachers, evaluators

and researchers. Nurses will have even greater responsibility for utilization and interpretation of technological monitoring devices and for functioning in lifesaving and life-sustaining situations. Nurse managers, particularly in hospitals, will have increased skills in budget control, labor relations and computer programming. Nurses will see their roles overlap more and more with those of other professions and will develop increased ability for interprofessional and intraprofessional consultation. Just as their knowledge will need to be wider and deeper and their collaboration with others more sophisticated, attention to standards and quality will have increased importance. Basic baccalaureate preparation for the professional nurse and continuing education programs will become the order of the day."

**Shella Embury** of Edmonton, one of the few nurses in Canada elected to public office, is a Member of the Legislative Assembly of Alberta. She agrees with the CNA president that baccalaureate preparation will be the minimum requirement for entry to the profession by the year 2000 and predicts that by then one nurse in ten will have completed studies at the master's or doctoral level. (The current figure is one in 140.)

"Educational opportunities will have expanded so there are more avenues for health care workers to move upward: technicians becoming professionals and baccalaureate nurses moving on to graduate studies, majoring in clinical specialties and a variety of other disciplines such as business administration, computer sciences, medical technology and political science."

What about independent practice, job satisfaction and salaries? Embury predicts that by the turn of the century one nurse in 20 will be in private practice, working alone or in a clinic, consulting in direct client care, conducting home visits and doing patient teaching.

"After a prolonged and difficult struggle, some nurses in some provinces will be permitted to collect fees from provincial health care payment schemes. Salaries will improve, too, as the competitive market for nurses is strengthened by the number of nurses employed by private

enterprise (occupational health). As salaries improve, there will be higher patient and client care standards and greater personal accountability on the part of each individual nurse to evaluate her own care for her clients.

"Job satisfaction will be high even though we will see a great deal of mobility across Canada. Nurses will work a four-day week (or less). Although salaries will be higher and nurses will have the satisfaction of earning more money, the cost of living will continue to rise and a higher proportion of nurses' salaries will go into taxes.

"The practicing nurse in the year 2000," Embury concludes, "will be an integral part of the health care system and will have attained a correspondingly high status level as a result of her professional contributions."

"The key person in making health care — the promotion and maintenance of healthful lifestyles and the prevention of illness — accessible, available and affordable to all." That's how CNA's executive director, **Helen K. Mussallem**, sees the nurse in the year 2000. Her vision focuses on "the nurse who is the initial contact for everyone in her segment of the community."

Between now and the turn of the century, Mussallem predicts, Canadian nurses will recognize their opportunity and responsibility to work within the framework of government policy to expand the health component and change the course of events that presently encourages misuse of illness centers such as hospitals and emergency facilities. Working through their national organization, nurses will develop a new model of health services that are, in fact, "accessible, available and affordable" to all citizens. They will be assisted in this effort by the spirit of government policy developed following the national "Health Services Review of 1979".

"The primary health care facilities of the year 2000 will be similar in principle to those envisioned in the early 1980's, except for the fact that they will also act as education centers for individuals chosen by their community to become health care workers. These workers will assist the nurse who will be the initial contact for persons in her segment of the community. Eventually, each city block, rural

area and isolated community will have its own complement of persons 'at their elbow' who can provide health guidance and act as 'interpreters of service' for the health centers."

The primary health care programs developed by Canadian nurses will, Mussallem predicts, be recognized by countries all around the world which are seeking ways of achieving the target of the World Health Organization — "Health for all by the year 2000". These governments will invite Canadian nurses to assist their own health personnel in developing and implementing similar plans in these countries.

"In this way, by the year 2000, Canadian nurses will have spent two decades in assisting with the development of policies and programs that helped to win the struggles for universal health — in Canada and abroad."

In a lighter vein, New Brunswick nurse, **Arlee McGee** of Fredericton, tries her hand at poetry to forecast the fate of nursing in the year 2000:

*"What of the Nightingales of years that are past,  
Human beings who nurtured and cared?*

*Can the crystal vial tell us how they fared?*

*The nurses of yesterday are in a broad range*

*They correlate health with the stresses of change,*

*They delve into research and direct the whole plan.*

*As 'Careologist Consultants', they know about man.*

*They know about needs, emotions and feelings.*

*They advise the technicians on all client dealings.*

*The picture fades...but there's one more view...*

*50 The Driveway. What's this? Something new?*

*A microwave tower emits to the nation*

*Holistic Health from our own TV station.*

*Unique public programs appear every day*

*Under now famous call letters—TCNA"*

But the last word goes to CNA president Helen Taylor who summed it up this way: "Above all, wherever nurses work in the year 2000, they will maintain the essential caring role that has always been the substance of all nursing functions and activities." ❖



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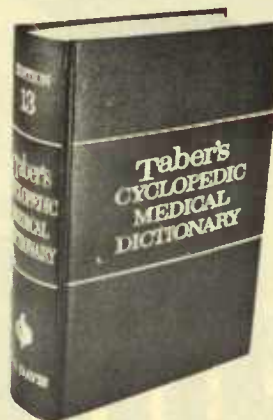
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# guillain barré syndrome

Laura Barry

*Treatment of this often terrifying disease which renders young and healthy people nearly totally paralyzed for weeks or months is palliative, and depends a great deal on good nursing care. The author discusses the importance of the triangle of nurse-patient-family, and how to use this relationship to the utmost in creative caring.*

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Guillain-Barré Syndrome is also known as acute infectious polyneuritis, acute polyradiculoneuropathy, or the Landry-Guillain-Barré Syndrome. The unusual nature of this disease lies in the fact that it attacks people who are apparently healthy and vibrant, leaving them totally dependent on others for their very existence.

The main factor in the etiology of this disease seems to be the fact that there is an unusually high incidence of its



occurrence after a viral infection, or a patient's receiving influenza vaccine. However, no real cause and effect relationship has been established between the vaccines and Guillain-Barré. After an infection, the body could produce antibodies which attack its own myelin; these antibodies then attack the nerve roots as they exit from the dural space, resulting in patchy degeneration. Lymphocytes accumulate at these sites and occasionally cause inflammation great enough to compress the nerve. Serum proteins transude into the subarachnoid space and the cerebrospinal fluid, which produces a rise in protein in the CSF.<sup>1</sup>

Guillain-Barré Syndrome is not specific to any one age group: it affects infants as well as the elderly. Although no actual figures are cited, most medical literature states that more males than females are afflicted.

Onset occurs generally within two weeks after a viral infection (influenza, infectious mononucleosis or an upper respiratory infection or tonsillitis). Frequently, the initial complaint is of "stocking-glove" paresthesia, or of facial weakness and weakness of the muscles in the lower extremities. Cranial nerve involvement occurs in some 50 per cent of the cases; involvement of the vagus nerve, the principal parasympathetic nerve in the body, leads to widespread autonomic nervous system dysfunction.<sup>2</sup>

The syndrome is self-limiting, and recovery generally begins within two to three weeks after the disease has reached its zenith. The recovery process works in reverse of the disease symptoms; it may take from six months to a year for a patient to recover all muscle strength.

Because any disease named a 'syndrome' is a collection or set of signs and symptoms that appear with reasonable consistency, certain criteria have been established for making the diagnosis of Guillain-Barré Syndrome. These are:<sup>3</sup>

- progressive motor weakness of more than one limb, ranging from minimal weakness to total muscle paralysis. Signs of weakness develop rapidly but cease about four weeks into the illness.
- areflexia.
- relative symmetry of symptoms. If one limb is affected, the opposite one is as well.
- mild sensory signs or symptoms.
- cranial nerve involvement. This occurs in 50 per cent of patients and is frequently bilateral.
- recovery usually begins two to four weeks after progression of disease symptoms has ceased.
- autonomic dysfunction, such as tachycardia or other arrhythmias, hypertension, postural hypotension all

support the diagnosis.

These are the principal signs of Guillain-Barré Syndrome, but other signs may exist in a number of patients:

- fever at onset.
- severe sensory loss with pain.
- progression of symptoms beyond four weeks.
- progression may cease without recovery.
- sphincter function is not usually affected but in some cases transient bladder paralysis may occur.
- CNS involvement. The disease is thought to involve only the peripheral nervous system, but there has been some evidence of CNS involvement as well.

There are only a few laboratory diagnostic procedures necessary for the diagnosis of Guillain-Barré Syndrome. Of prime importance is examination of the cerebrospinal fluid, obtained by lumbar puncture, for protein levels. Often the CSF will appear normal, but the total protein is increased. A white cell count and sedimentation rate are useful, but often they will be within normal limits, unless still affected by the patient's previous illness.<sup>4</sup> Pulmonary function tests may be done to assess the degree of paralysis in respiratory muscles. Nerve conduction studies too may determine which nerves are affected.

Treatment of Guillain-Barré is palliative and supportive. At this point in time, there is no known treatment or drug that can halt the disease process and speed the patient's recovery.

Steroid therapy has been tried, but its use is as yet controversial. The principle behind the use of steroids is their ability to control autoimmune response, but the value of this therapy in Guillain-Barré Syndrome has not been established.<sup>5</sup>

Ventilation assistance may be required depending on the degree of respiratory embarrassment from muscular weakness.

One cannot overlook the importance of good nursing care in the treatment of patients with this disease: frequent turning, good skin care, chest physiotherapy, passive exercises and accurate monitoring are all of vital importance.

#### The nurse-patient-family relationship

The relationship between the nurse, her patient and the patient's family is important in the treatment of any disease and subsequent rehabilitation, but especially so in Guillain-Barré Syndrome. Not only must the patients with this disease endure an intense physical adjustment, but they must make a profound psychological one as well. The patient looks to the nurse to meet her physical needs just to keep her alive; Guillain-Barré Syndrome is no less agonizing for the family. Often they wish

they could trade places and alleviate their loved one's suffering. They feel helpless as they watch their spouse, parent or child go through stages leading to eventual acceptance, similar to the five stages of accepting death.

Consider this — you are a healthy young girl. The only recent medical problem you've had is a little cold. Now you have a "pins and needles" sensation on your hands and feet and are feeling weak; the doctor is telling you that this may progress to the point where you require a tracheotomy and a respirator just to breathe! You think to yourself — "not me, I'm healthy".

It must be a terrifying experience. You keep denying the fact that you are suffering from this disease but all the while you are getting weaker and weaker. "*No, It Can't Be Happening To Me!*"

Unfortunately, the disease progresses to the point where the patient can no longer use verbal denial as a defense mechanism, and anger takes over: "Why me!?" This anger is a natural protective mechanism, not a personal attack on anyone. It is directed at the disease itself and the nursing staff must keep this in mind, for if they interpret the anger as a personal attack, they will become frustrated with and resentful of the patient.

The point at which the patient realizes she cannot control her disease and that she has no choice but to see it run its course is when she begins to bargain with the nurses. The realization that she has lost control, however, frequently leads to depression which, in the case of the patient with Guillain-Barré Syndrome, can be overwhelming. The patient needs a great deal of support, from both nurses, friends and family, if he or she is to pass through this stage successfully. Support doesn't have to be a soliloquy of encouragement — just spending time with the patient, just touching, are as effective.

With good nursing care and emotional support, the patient with Guillain-Barré Syndrome can reach a stage of acceptance; hopefully, by this time the disease will have reached its zenith and ceased to progress further.

But what exactly makes a good 'nurse-patient-family relationship'? Without some concrete suggestions, this phrase is just an auspicious-sounding title for something that may or may not truly exist. What factors contribute to the development of a good, therapeutic nurse-patient-family relationship?

One must look first at what the nurse contributes. She is an individual, a person with her own set of moral standards and values; she has her own unique ideas of what a nurse should be. Too often though, the nurse has unrealistic expectations of herself. She



tries to be all things to all people and in the end, drained both physically and emotionally, she can no longer help the people she wants to. The nurse fills a variety of roles: she can be a social worker, mother, problem-solver and healer, all in the course of one day. Unless she looks after her own needs too, and recognizes the potential drain on her system, she may become merely a task-oriented functioning unit — an apathetic frustrated shell.

The patient, second partner in the relationship, is an individual too and his or her contributions to the interactions are affected by his own cultural background, moral standards, his perception of disease and by the nature of the illness itself. Obviously the degree of alertness or awareness on the part of the patient is going to be a major determinant in what he can contribute to any relationship; a comatose patient will not be able to contribute a great deal.

The third member of the 'triangle' is the family whose importance should not be underestimated. Depending upon the closeness of the family unit, the family and the patient can sometimes be considered as one entity. Frequently doctors and nurses alike feel as though they are treating the family as well as the patient. The family's contribution to the nurse-patient relationship is immense. At times, the family can act as a pivotal point around which the nurse can function; they may be invaluable as a source of information, for example. The family's needs must be considered too and met in order to promote a comfortable environment for all concerned.

By recognizing the importance of the family unit, the nurse can see how the family can help or hinder a patient's acceptance of her condition, how they can support or undermine the intentions of the medical and nursing staff. If the nurse does recognize the family's importance, then she can use it to her advantage.

Once the triangular relationship between nurse, patient and his family has been recognized and assessed, how does the nurse caring for the critically ill patient with Guillain-Barré Syndrome enhance this relationship to work for the benefit of the patient?

It has been said that language is God's gift to man, and certainly, in the hospital as nowhere else, communication is of prime importance.

The nurse should converse in a calm, reassuring manner at all times, exhibiting not only her professionalism but the fact that she too is an individual who cares. While guiding conversation, she should give opportunity for patient or family to ask questions; answers should be as specific as possible, not broad generalizations that might apply to anyone. Interactions should be

encouraged, not cut off. Phrases such as "yes, go on," or repeating what a person has just said show that the nurse is really listening and interested in what she has heard.

Needless to say, it is just as important for the patient and his family to be good listeners, but when anxiety levels are high, understanding and full comprehension of all that has been said by nurse or doctor is often difficult to achieve. Staff should be aware of this, and be ready to repeat information if necessary.

Also true is the edict that "actions speak louder than words". In the working phase of a good nurse-patient-family relationship, all three partners work together toward a common goal. Although not always the case, family members are usually eager to assist in the care of their loved ones. Helping the nurse with such simple tasks as the daily bath or making the bed can make a family member feel that there is something he or she can do to help, even in this overwhelming situation. The family will not feel they have relinquished ownership of the sick individual to the hospital.

Nurses tend to react to Guillain-Barré Syndrome on two levels: first, from a humanistic point of view, it is difficult to watch this disease attack a healthy young person and gradually render them totally immobile and dependent upon machines and care-takers for their survival. Secondly, nurses look at the illness from a medical viewpoint, recognizing that the patient is a challenge to all the nursing skills they possess. Hopefully, these two different outlooks can be integrated.

#### **Linda — A Case Study**

Linda was just 20 years old when she was admitted to hospital with signs of Guillain-Barré Syndrome. Her earliest symptoms were a "pins and needles" sensation in her legs and arms, feeling of thickness in her tongue and loss of sense of taste, nausea and vomiting and weakness of girdle muscles, all of which occurred rapidly in a 48-hour period.

Noting her past history, the admitting physician wrote in her chart that Linda had had infectious mononucleosis five years previously but had been well until three weeks before admission when she had caught a cold which lasted for about two days. One week before admission she had had a wisdom tooth or third molar extracted under local anesthesia.

What follows are excerpts from the medical progress notes which indicate the development of Linda's illness.

30/5/77 Patient admitted. On examination: sensory. Touch intact; vibration, intact; pinprick,

parasthesia extends 2 inches above knees and 6 inches above wrists.

Reflexes decreased both sides, Babinski not evident. Gait — can no longer walk, too weak.

Motor strength decreased both sides.

5/6/77 Motor weakness slowly progressive.

6/6/77 Tracheotomy performed.

7/6/77 Patient put on respirator at 0400 hours due to respiratory distress.

9/6/77 Mild improvement of 'neuro' status.

10/6/77 Gradual improvement of polyneuropathy beginning. Main problem now is dependence on respirator which is probably psychological.

20/6/77 On assisted ventilation during the day and on automatic ventilation at night. She is nervous when off respirator, has tendency to hyperventilate.

26/6/77 Continues to improve in muscle strength in all extremities.

2/7/77 Tracheostomy tube corked.

4/7/77 Tracheostomy removed.

15/7/77 Progressing well. Eager to go home and pushing herself.

22/7/77 Discharged.

In reading these notes, one can see how Linda's illness followed the pattern described earlier for the development of this disease: gradual worsening to a peak, and then improvement, slow at first, but soon more dramatic. She was hospitalized for a total of seven weeks, during half of which she was almost completely without voluntary movement.

After Linda had returned home, I interviewed her, her family and the staff nurses on the unit where Linda had been hospitalized, to discover how the nurse-patient-family relationship had figured in her supportive care.

Linda said, "My family played a very big part in my time in the hospital and if the family is willing, I think they should be included in most aspects of hospitalization..." Her father commented that "Our role was supportive, we could do nothing else. We wanted to be there at all times and we felt she wanted us to be there."

For the nurses, an honest appraisal of the experience led them to admit that although Linda's hospitalization had ended successfully, there had in fact been times when the nurses' relationship with both patient and family had been strained.

Looking back helped them to understand what they had done when things were going well, and what had caused things to go wrong.

One nurse outlined the problems she felt important in caring for Linda: she felt



frustrated when she was unable to understand what Linda was trying to tell her, and she often felt unable to alleviate her fears. Difficulty in making Linda physically comfortable was expressed too, and in helping her to cope with certain things that had to be done such as tracheotomy care and suctioning. Helping the family to understand the illness and assisting them in coping with it was another problem. But underlying all these problems was the very basic and frightening knowledge that Linda depended totally on the nursing and medical staff for survival.

Another nurse listed what she thought Linda's emotional needs had been during her illness: there was the need to talk and to be listened to, to feel safe, to be free of pain, worry and fatigue, to feel accepted despite her condition, and the need to be independent.

The nurses wished they had had more conferences about Linda's care: all the nurses interviewed realized the importance of these conferences, noting that they benefit not only patient care, but meet the nurse's needs as well. By talking with their peers, nurses come to realize that it is alright to get angry and frustrated at times. They realize that they need not feel guilty about these feelings and they become aware of the dangers of always suppressing their ill feelings. Nurses are human after all, and everyone has "bad" days; it is comforting to know that one is not alone. A nursing conference can give a nurse the encouragement she needs to go out and try one more time.

One nurse in particular noted the fact that the patient with Guillain-Barré Syndrome requires a consistent approach from nurses, and in retrospect, she had a suggestion:

*"Perhaps there could have been a 'core group' of nurses assigned to Linda. For example, a group of six or eight nurses could have been selected when Linda was first admitted. The schedule could have been planned or the nurses picked from the rotation so that one of the special nurses would always have been on duty."*

Other nurses involved in Linda's care said they had at times felt resentful of or actually afraid of the family's presence, but at least one was finally able to understand the family's position:

*"I wanted to make Linda and her family more at ease and comfortable. I thought a lot about how I would feel in Linda's position and came to the conclusion that I would want the same kind of things — one being my parents near by."*

And, as Linda's father said, the family wanted to be near Linda too; he

spoke of the hope the nurses gave him and his wife, and felt the nurse's air of confidence and faith in Linda's treatment to be important. It was a time of great trial for Linda's family:

*"Almost instantly it seemed a healthy, vibrant, aware girl is transformed into a being that was so immobile she could not fully close her eyes. Rolling her over was like trying to move a garbage bag full of water. A machine was pumping air into paralyzed lungs. Not only couldn't she talk, almost all communication came to a halt. To the family, this is mind-bending."*

It was evident that a trusting relationship between Linda and her nurses was necessary for her to be able to regain her independence, even after the worst of her illness was over. In the doctor's notes, her psychological dependence on the respirator was well-documented, and the nurses had to work hard to encourage Linda to wean herself from the machine. Knowing that the nurses would not force her to do anything before she was ready was important to Linda; they made her feel that the choice was hers — she could stay off the respirator for as long as she felt it was possible.

*"...Nobody wants to stay attached to a machine forever. When the nurses explained that the tests showed that I was strong enough to breathe on my own, I didn't want the machine any more."*

#### What does it all mean?

In a disease like Guillain-Barré Syndrome where the treatment can only be supportive, that basic philosophy of care applies to both physical and emotional care. For nurses, this means not only using basic nursing skills to their utmost, but developing a good relationship with the patient and her family to support everyone through to the resolution of this frightening illness.

A good nurse-patient-family relationship can have excellent therapeutic effects, and it behooves every nurse to be aware of how she can foster such relationships.

Linda's father spoke of what he thought the care given to his daughter meant:

*"Good nursing...is enlisting all the help you can get from the patient, family and friends, and then with (the nurse) as the focal point willing the patient to live with all the strength you can muster. All of Linda's nurses in Intensive Care did just that — they cared, intensively."* ❖

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# Implementation of an alternative



Traditional delivery room

## the Birth Room

*Ellen L. Rosen*

**Last October, CNJ featured a special section called Childbirth Today in which several nurses spoke of the need for alternate birthing procedures for their patients. Here is how one hospital with a family-centered philosophy implemented the concept of the Birth Room.**

The recent rise in consumer interest in childbirth practices has led to the development of several alternative delivery methods: a small group has chosen home delivery as their alternative, but the majority — recognizing that the hospital setting provides the maximum opportunity for physical safety and psychological well-being — have been working to encourage hospital administrators and physicians to offer a more satisfying birth experience within the hospital.

The rationale for these consumer demands varies: the most frequent complaint refers to the sterile institutional appearance of the average hospital delivery room which many patients say increases their anxiety, and suppresses the natural expression of emotion in the birth process. Women add that they feel the excitement of the moment is sometimes lost in the sterile environment, and they reject the 'sick' role inferred in becoming a patient in hospital.

Another common complaint derives from the transfer from labor bed to delivery table necessary in traditionally-designed labor-delivery areas. In most hospitals, labor is managed in one room and delivery in another; however, this practice interrupts the continuity of birth. Practically, mothers find it very difficult and uncomfortable to move from one bed to another at a time when they should be devoting all their energy to the experience of giving birth.



Complaints in general reflect a desire on the part of women to have more control over their labor, and to be more actively involved in the management of their labor and birth. They wish to "deliver" their babies, rather than to "be delivered of" infants.

As a logical extension of the family-centered philosophy of maternal-child care of our hospital, the Victoria Hospital in London, Ontario, a combined labor/delivery room seemed to us to be an idea that was worth trying.

### Planning

Prior to actually planning the facility, we had to undertake several pre-planning activities, including ward conferences with staff nurses and meetings with the chief of the obstetrical service and the nursing service co-ordinator. Their cooperation was essential and their response to the idea was enthusiastic. Additional legwork included calls on other health care agencies with existing Birth Rooms and talks with infection control personnel about logistics.

With a better idea of what was required, we decided to undertake a three to six month trial period. We chose the largest labor room to use as our alternate Birth Room in this period, where the patients and their birth partners would labor, deliver and recover, all in the same room.

During the trial period, patients were selected according to the following criteria:

- They must be self-selected: ie.

they must expressly request this type of delivery and discuss alternatives with the physician.

- They must have completed a childbirth education course.
- They must have had adequate prenatal care.
- They must have a clear understanding of guidelines for initiating the move to the delivery room if necessary.
- There must be no evidence of risk factors.
- Presentation must be vertex.
- Patients must be prepared for natural childbirth. Epidural anesthesia would necessitate delivery in routine fashion.

Guidelines detailing the philosophy, criteria and implementation were drafted and circulated to the nursing and medical staff; they specified that any patient requiring fetal monitoring, induction of labor or any other intervention, was to be delivered in a traditional delivery room. However, even with our guidelines, several conferences and mock set-ups, there were still problems to solve after the first few deliveries.

There were questions regarding the sterile technique and extensive draping that are the norm in a traditional delivery room. We stressed the importance of handwashing and perineal preparation but it was decided that extensive draping of the patient was not necessary. The nurses continued to set up a sterile instrument table and gloves were worn by the physician.

Another problem was related to the definition of "high risk" and "low risk". Some physicians were using Syntocinon® (oxytocin) to augment labor and did not agree that this disqualified the patient from delivery in the Birth Room. Some felt too that artificial rupture of membranes without the use of oxytocics was an acceptable means of induction for patients in this room, while others believed it disqualified the patient, based on the criteria outlined in the guidelines.

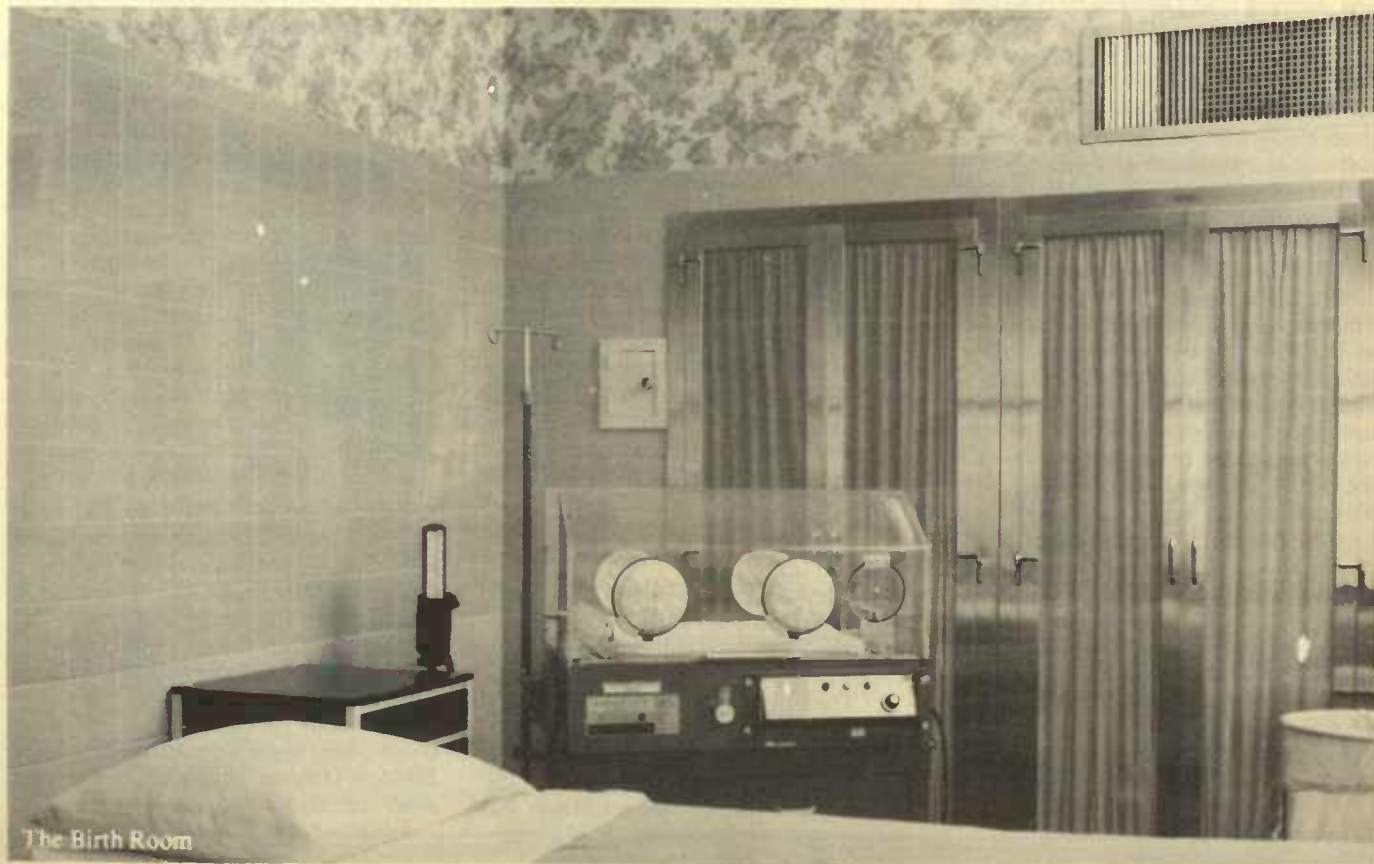
The physicians had concerns about adequate space within the room should an emergency occur. This turned out to be a valid point as even with a minimum of essential equipment in the room, with father and a nurse and physician, it did prove to be cramped.

### Back to the drawing board

At the end of the trial period, we evaluated our interim Birth Room based on feedback received from both patients and professional staff members involved in the project.

Records had been kept of each labor and delivery, and during the trial period, of the 15 patients who delivered in the Birth Room, all their infants had had apgars of 8 to 10 at 5 minutes.

One-minute apgars were 6 to 9 with the majority scoring 8. Where no episiotomy was performed, patients all had perineal tears of first or second degree. Nine patients were not able to deliver in the Birth Room; 6 of these were primiparas, 3 multiparas. In all but one case the



The Birth Room



reason for the change was that the patient had opted for epidural anesthesia during the course of labor. However, those who did deliver as planned were very pleased with the room.

Feedback from the professionals revealed ongoing concerns about inadequate lighting, cramped space and relative distance of resuscitation equipment. The most persistent problem was that some of the patients who had requested the service did not meet the department's criteria of "low risk". They may have been acceptable at an earlier stage of pregnancy, but upon admission, were found to be at some degree of risk. These patients were then faced with disappointment and a situation which they did not fully comprehend. Those who required intervention during the course of labor, such as intravenous therapy, fetal monitoring or Syntocinon augmentation, were frustrated by their inability to meet their personal goals. A few even delayed the decision to have prescribed clinical intervention because of their desire to deliver in the Birth Room.

We decided that further study was required in order to achieve a more workable alternative. Increased flexibility and additional space were the most important features. After additional discussion, we decided to renovate a traditional delivery room. With some renovations and redecorating, we would be able to achieve all the objectives of the Birthing Room. We drafted plans, met with the maintenance department and planning board and finally received approval for renovations.

The renovations were accomplished with relative ease: the ceiling was lowered, a washroom added and we decorated with some finishing touches of soft-colored wallpaper and sheer curtains. Equipment is stored behind a wallpapered screen, and built-in O.R.-style glass cupboards were draped with fabric. Oxygen, suction and anesthesia equipment were left in place. The labor-delivery bed is a convertible model made by Stryker\* and has an adjustable back support, stirrups and other features that allow for flexibility in the case of a more complex delivery. A sitting area in the room was provided for the mother and her coach with soft indirect lighting.

We felt the advantages of the new room would be the increased space and the increased flexibility of use, both of which would allow for birth in a home-like atmosphere which allowed for emergency intervention if necessary.

The criteria for the Birth Room patients were revised; as before, they emphasized the preference for 'natural' childbirth. New guidelines indicated that

patients selected for the Birth Room must have a clear understanding of the indications for clinical intervention if it were needed; it was decided too that although presentation of the fetus should be vertex, breech presentations could be assessed on an individual basis. Patients do not have to be moved to another room for intervention, such as fetal monitoring.

At the time of writing, 51 patients have requested to deliver in the newly-renovated room, and 47 have been successful. (The four patients who could not were delivered by Cesarean section in our Section Room.) For all the patients, a family-oriented birth was achieved in a subdued and relaxed environment.

**Organizing motherhood** Once a patient and her partner have decided they wish to have their birth in this facility, they usually discuss their plans with their physician. A meeting with the head nurse or clinical nurse specialist is then arranged to:

- familiarize the couple with the facilities
- gain understanding of the couple's objectives
- inform couple of the hospital guidelines, to decrease discrepancy between their personal philosophies and that of the hospital
- answer questions
- inform the couple of alternatives in postpartum care such as mother-baby care, rooming-in, early discharge and home care.

After getting acquainted, the patient and her partner are given a tour and a further opportunity to ask unanswered questions. The name of the patient, her E.D.C. and doctor's name are recorded in a log in the delivery room. This log is useful for information and for prediction of Birth Room use which is helpful to the staff; however, the Room is assigned on a first come, first served basis.

A copy of the guidelines was sent to each physician practicing at our hospital and when the renovations were completed, additional publicity was undertaken in order to inform the public about the changes that had taken place. Notification was also sent to Childbirth Education Groups which aroused further interest and resulted in many calls about our service.

### Conclusion

The labor-delivery or Birth Room has proven to be a quiet and relaxing environment which enhances the experience of childbirth.

The original plan was to meet the needs of a very small group of patients who wanted a 'natural' birth in a home-like atmosphere that provided the safety of the hospital; the result was that we are now serving the needs of a much larger group of patients.

The attention devoted to the project and the discussions between physicians and nurses have increased professional awareness of the desires of many mothers and their partners to be actively involved and in fact to participate in the birth of their child. Now, we are able to give them increased flexibility and individualization of care inside the hospital environment.

Having a baby today is safer than ever before. Today's obstetrical health care consumer has a far broader knowledge base than did mothers of the past: people want a shared birth experience and childbirth with dignity. Humanization of the hospital environment can help to enhance childbirth — one of the most beautiful and satisfying of all human experiences. ♀

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\*available in Canada from Down Surgical Ltd., Toronto



# An open letter to the nurses of Canada

Jane Melville White

I've been wondering how I could show my appreciation for your kind care during my recent hospitalization, especially for your help during the month before my baby was born and later, when I was re-admitted to help gain control over the grief resulting from his stillbirth.

My talents run mostly in the direction of writing; that is why I've chosen to express my thanks this way.

Whenever I have entered hospital because I have been depressed, at least one staff member has expressed the concern that "we aren't trained to deal with mental health patients." I sympathize and wish that I could make it easier for you, but at the same time, accept the fact that my coming into hospital makes life easier for me.

The purpose of this letter is to reassure you that you do so many things right. I won't name names — I hope you'll recognize yourself — but I want all of you to feel, "Yes, I've done (could do) that."

About names...I appreciate name tags and/or nurses who introduce themselves, "Remember me, I'm ....." It is difficult to talk to someone whose name you don't know or, worse yet, feel guilty about forgetting.

The decision to enter hospital always adds panic, guilt and a sense of failure to the other emotions I'm already finding impossible to handle. This is followed by relief when I actually reach my room and know "somehow it will be okay." A verbal reinforcement from the nurse to that effect is very encouraging at that moment.

The admission form gives you the chance to find out what is really bothering me. I appreciate your allowing me to get to my room and calm down before trying to complete the form. Also, it's nice that you waited to come into my room until you had time to listen, instead of when you had to rush; this was better for both of us. In those first few hours, when all the feelings I'd bottled up so long had to be aired, the admission questions provided an opening.

Another thing you do right is allowing me to talk to you: all those leading questions and that prompting really help. For example, "Did you want to be pregnant?" "It's okay to admit you

don't feel able to care for a baby." And later, "How did you feel about losing the baby?" "It is going to take awhile to get over it."

You recognize that there is no easy answer but imply that I will be able to work things through.

Most nurses understand the value of touch. You used it so effectively in so many ways: like catching my lower leg to gain my attention without startling me if I were resting at thermometer time; like using both hands to take my pulse — the second to hold my fingers in a gentle "surrounding". When I was having a bad time, I appreciated the firm grasp of a hand helping me to hang on to reality.

Back rubs feel so good when the tension builds up, especially when coupled with leading questions like, "Is something bothering you tonight?" or more generally, "How was your day?" The latter is a good question because sharing what I've figured out — the positives of a hospital stay — reinforced them so that I went to bed feeling I had grown in understanding that day.

"Can I get you anything?" is *not* an opening to talk. On the other hand, "We're here if you need anything. Just ring or stop us in the hall" is appropriate to both physical and mental needs. The pulling down of the call bell arm really reinforces those words.

Once, right after visiting hours when she was usually rubbing backs, I stopped one nurse in the hall. "Have you time..." (I hated to ring the bell and tried hard not to.) She sat and listened. Both of us realized the time limitation but as she left, she reassured me, "We all need someone to talk to sometimes."

Comments like these are helpful: "You're not the only (or first) person who feels like that." "It's normal to react that way to this situation." "I've felt that myself." Such statements reassure me that: a) I'm not a "freak", and b) I'm still accepted despite the thought.

Of course, some nurses feel more comfortable listening than others, and naturally I looked forward to the shifts when these nurses were on duty. I especially appreciated the nurses who sat down saying (or implying by their question), "I finally got a couple of

minutes to visit with you." The nurses who gave time when they had, or made time, really helped. Time — so often it boiled down to that when you seemed to be running up and down the halls with so much to do. In spite of that, I had to admire the personal attention you managed to give to each of your patients. The smiling, "You're lookin' good" as you passed my room or met me in the hall, the "how are you doing?" as you took blood pressure helped to prevent a sense of isolation.

Once, I knew it was report time, but I also knew I needed someone. A nurse answered my call and, as things began to get better for me, I apologized, "You have so much to do." She gave a helpful reply, "If my staying will help you regain control, I'll stay a little longer."

I could mention other things you did that were helpful... things like bringing me a cup of tea when I needed it, like letting me have my sewing machine in my room, like screening visitors. But the best support came from simply knowing that you were pulling for me...encouraging me to be well and happy again.

"...help you regain control..." That was the phrase that you used. It made me realize why I was in hospital, that what I needed was a breathing space, a rethinking place, and you and your hospital gave me that. The responsibility for control is mine: it isn't something you or anyone else can give, so you have no reason to feel inadequate or guilty.

You helped me when I needed help, in all the ways you could and now that I'm out, I want to say "thank you". I hope I won't be back for a long time but it is nice to know that you are there. ♡  
Sincerely

*Jane White*

Jane Melville White originally wrote this letter for the nurses at Kindersley Union Hospital in Saskatchewan after being hospitalized there. Jane describes herself as a freelance writer, wife and mother of a youngster who just started school this year. She is active in her community and her church.



Rose is expecting her second stillborn child after intrauterine death was confirmed five days ago. At 38 weeks gestation, she is now awaiting the induction of labor by the intrauterine saline method. Rose knows that her baby will not be born alive and speaks often of wanting to see the baby when it is born. She recalls the birth of her first baby, also stillborn: "Actually no one ever asked me if I wanted to see the baby. I wished I had seen him. This time I must see the baby."

Anna is delivered of a stillborn male infant; the cause of death appears to be torsion of the cord. She refuses to see the baby, but states that perhaps her husband will want to see the baby when he arrives. Anna's husband Paul declines despite being told that the baby is perfect in appearance. The next evening, following a discussion with the nurse and Pastoral Care worker, Anna and Paul ask if they may have the baby present with them in the chapel for a short memorial service. Unfortunately the baby is already under the care of the local funeral director, burial having been planned for the following day.

Eva gives birth to a premature male infant of 22 weeks gestation. She is heavily sedated, having been brought to the hospital convulsing, with a diagnosis of severe eclampsia. She was unaware that within a few hours of birth, her baby was transferred by air ambulance to a center equipped to provide intensive care for the very premature infant. Within 48 hours, her baby dies. In the days that follow, Eva cries often, has long periods of silence and appears severely depressed. Her most frequent comment or conversation is centered around the fact that she has never seen her baby. "I'll never know what he looked like. Other people have seen my baby, but I'll never see him. I don't feel I've had a baby. I don't remember anything!"

Sylvia and Charles have just lost their first child because of a spontaneous abortion at 16 weeks gestation. Sylvia does not see the fetus, she lies passive and unresponsive following the abortion, sleeping most of the first 12 hours. Only when her husband is present does she show any signs of interest.

# Letting go

*"The primary goal in support of the mourner is to be genuine and realistic about death, his loss and to help him face the psychological present, whatever it is."<sup>1</sup>*

Sheila Parrish



Photo St. Joseph's General Hospital, North Bay

All of these women have something in common, they are grieving the loss of their babies through stillbirth or early neonatal death, a situation which is compounded by the inherent nature of the mother-baby relationship. How can nurses help these bereaved parents to commence the process of "letting go", an essential phase of grief work?

The specific circumstances surrounding perinatal death warrant special consideration in the management of grief. By considering the significance of visual and tactile experience for the parents and the stillborn infant, and secondly the value of participatory inclusion of the parents in a memorial service that places their loss in a spiritual and religious context, I believe bereaved parents may be assisted to face the reality of death and move towards resolution of their grief.

As health professionals, we have become increasingly aware of the need to become more knowledgeable about the needs of the dying and the bereaved, however, death is not a frequent experience in the obstetrical unit. Shorter hospitalization and earlier discharge of the postpartum patient into the community, where other support systems take over, means that the obstetrical nurse seldom sees the resolution of the grief process in the bereaved parents following stillbirth or

early neonatal death. Hopefully nurses' intervention at the time of crisis will result in the healthiest adjustment for all concerned.

Research into the long term effects of grief management has revealed that many people become sick, either physically or emotionally following the death of a loved person.<sup>2</sup> The death of an infant may have a permanent effect on the parents, as they internalize their feelings of helplessness, acting them out in their social life and marriage, with a subsequent increase in marital problems.<sup>3</sup> Studies of adolescent pregnancies have shown that "Adolescents who do not fully address the process of mourning, after abortion, miscarriage or infant loss, may face a greater risk of subsequent pregnancy."<sup>4</sup>

Grief is a complex emotion that varies from one individual to another. Each person has his or her own unique style of grieving; the existing skills for coping with death are determined in part by cultural attitudes and personal beliefs and the individual circumstances surrounding the loss. The mother and father may face the same loss but be at different stages of grieving. This problem of grief resolution is compounded in the case of the stillborn or early neonatal death, by the special nature of the relationship between mother and baby existent at every birth.



# New dimensions in assisting bereaved parents

All pregnant women experience some fear that the baby will not be normal and may die, nevertheless, the infant is usually anticipated with joy. Both parents develop a fantasy image of a perfect infant that may not be at all like the infant they eventually have. The mother moves through the normal phases of the pregnancy, acknowledging the fetus within her as real, then a feeling that she and the baby are one and finally accepting the reality of the baby as a separate being. However a state of anxiety normally exists at the end of the pregnancy when acceptance of the reality of the baby as a separate being and a future love object cannot completely overcome an inner unwillingness to give up this gratifying union of mother and baby as one. This is usually resolved after the birth when the love relationship is established.<sup>5</sup>

During the pregnancy it is difficult for parents to picture their baby in an objective form; consequently after the birth there is an intense need to examine the new baby directly to give him an identity. Doing this allows the parents to organize their concepts and feelings of the baby in relation to themselves and their behaviors or responses to the child.<sup>6</sup> At birth, the mother who is able to hold, see and hear her baby quickly accepts the reality of the baby as a separate individual. Complete identification, however, may take several hours, days or even weeks. Despite the happiness and excitement following the birth of the healthy baby, there is already a form of grief in process. The normal childbirth experience has been described as one in which bereavement, often not acknowledged, exists.

In the case of a stillborn or neonatal death, the mother must face the reality of the death plus the fact that the outcome of the pregnancy was not successful. She will need to break the ties to the lost child, but she will also need to have first identified and accepted the child as hers. Current childbirth practice places heavy emphasis on the need for the mother and baby to be physically close immediately after the birth. Should not the same effort be made in the case of the stillborn infant? Consider also the premature or sick infant who is whisked away to receive appropriate care and may die before the mother has a chance to claim her living child.

In the hushed, uncomfortable atmosphere that follows the stillbirth, the delivery room nurse does her best to support the mother and, if he is present, the father but, in my experience, the subject of seeing the baby or holding the baby is not often broached, especially if the infant is disfigured or abnormal. The parent has usually been the one to ask to see the baby and, in retrospect, I feel that not too many did! How many would have chosen not to experience their dead baby will never be known, of course, but on the other hand, how many more would have seen or held the baby had someone suggested to the parents that this was an acceptable and normal thing to want to do? Naturally, not all bereaved persons want visual or tactile experience of the deceased, and the wishes of each individual must be respected. As well, the bereaved person may be so overwrought that he or she is unable to comprehend the situation or even listen to the discussion in order to make a decision.

## Viewing the body

What is to be gained by seeing the body? Two important purposes served in the custom of viewing are *realization* and *recall*.<sup>7</sup> The bereaved are more aware of the death in that seeing is believing, and an image is provided for recall of the deceased. "The image becomes the working basis from which reorganization of life takes place. When the image is not clear and the deceased is put out of the mind, the mourner may begin to create illusory pictures that serve ill as a foundation for rebuilding life."<sup>8</sup>

Where there is no proof of death, denial is apt to be prolonged. It is not difficult to understand why the mourners who have the most difficulty resolving their grief are those who never get to see the body because of drowning, air tragedy or other situations in which the body is never found. In a study of war widows in Israel, the lack of presence of the body of the deceased delayed even the start of the bereavement process for many of the wives. Death became a reality only after some physical evidence or encounter occurred such as seeing the grave or receiving something that belonged to the deceased.<sup>9</sup> Often persons who are suffering illness as a result of unwisely managed grief cannot remember very well the image of the deceased. "The recognition of death is a necessity for continuing life, and grief is a necessary and unavoidable process in normative psychological functioning."<sup>10</sup>

Because of her toxic condition, *Eva* was under heavy sedation and did not become alert in time to see her infant before he was transported by air ambulance to a larger center for intensive care. The baby died two days later. *Eva's* constant cry of anguish was that "I never even saw my baby. If only I could have seen him once." I attempted to give *Eva* some visual idea of what her baby had looked like, in terms of development. By showing her pictures of a 24-week-old fetus, she was able to understand some of the problems of prematurity. She smiled for awhile and was grateful, but she wanted to see some resemblance of her family in the baby. I was acutely aware of the importance of identification for *Eva* and wished that someone had taken time to take a photograph of her baby before the transfer. As far as *Eva* was concerned, it was as if she had "never had the baby". Physical symptoms that could possibly be related to unresolved grief caused *Eva* to be readmitted to hospital twice in the postpartum period and currently she is under psychiatric follow-up.

Viewing the body is never pleasant and sometimes we think it is kinder to spare the bereaved this additional agony. As I look back, I realize it has often been the first reaction of the father of the baby to say he doesn't want his wife to see the baby, saying "she will be more upset" or "she can't take it". Some nurses and doctors operate from their own feelings, unconsciously not wanting to be part of the discomfort involved and accept the parents' initial reaction too readily. A parallel can be drawn in the case of those who advise the single parent giving up her baby for adoption not to see the baby, thinking that it will be less painful. They do not realize "that the choice is not between pain and no pain; but between wisely managed suffering and unwisely managed suffering".<sup>11</sup> In a study of unwed teenage mothers, those mothers who saw their babies were able to work through their feelings more quickly and had fewer long term adverse effects whereas women who did not see their babies developed disturbed emotional patterns of behavior and tended to withdraw from human relations. Denying the reality of the basic relationship between mother and child, prevented the normal process of mourning from being employed.<sup>12</sup>



At an appropriate moment and as soon as possible the nurse should make the parents aware of the opportunity to hold, see or touch the stillborn baby if they wish. In the last three years, I have witnessed 37 stillbirths. The initial reaction of 25 of these mothers was not to see the baby, but, following gentle explanation of the value of seeing the baby and allowing the parents some time alone to discuss how they felt, approximately 20 changed their minds. None have regretted the decision, the usual comments being, "I was afraid to look and it was hard, but I'm so glad I did." "I feel that he was really mine." "I would have resented it later if my husband had seen the baby and I hadn't."

If the mother is under sedation and unable to participate, or if she changes her mind after the baby has been transferred to the funeral home, it is important that she receive concrete information about her baby, including sex, weight, coloring and so on. Positive comments concerning the formation of nails, hair and peaceful expression are especially needed in the case of a deformed baby. In addition most mothers treasure receiving the name bracelet and an information card normally placed on the crib. Following baptism of the baby, a certificate of baptism should be offered to the parents; this comforts them in their spiritual need, helps the mother unable to see her baby accept the reality of birth and the finality of death and also places the baby in the context of a church community.

Whenever possible, the parents must be prepared to see the body. Asking them if they have ever seen a dead body before and discussing expectations, opens up opportunities to explain about skin change, maceration, rigidity and coldness. In addition, the nurse must recognize and face her own feelings since how the nurse perceives the baby will affect the parents' response. Wrapping the baby in a warm blanket, holding the baby in a caring way close to her body, the nurse conveys to the parents that the baby is acceptable to her, especially important if the baby is disfigured or abnormal; and in turn the parents may be influenced in their feeling toward the baby as desirable to hold.

*Rose had repeatedly informed the nursing staff that regardless of how the baby looked, she wanted to see her child. She had been denied seeing her first stillborn at another hospital, two years previously. Following the delivery of a macerated stillborn female infant, Rose received the routine post delivery care and was transferred to the recovery room to await the arrival of her husband whom she felt would also want to see the baby. She did not wait however. About 15 minutes later she called me, said she was ready to see the baby and was it possible to have her mother present. Rose was prepared for what she was to see as we had talked about this on several occasions during the days before delivery.*

When I brought the baby to her, Rose sat upright in bed but kept her arms and hands close to her body. I unwrapped the blanket to expose the body which was moderately macerated and misshapen. Although the skin was peeling and some fluid escaping, I had deliberately left my gloves off not wanting to convey anything to Rose that might suggest I found the baby undesirable. I lifted the baby's hands and feet and we counted the toes and fingers together. Rose asked to see the baby's back. Since the fetal skull had collapsed, the baby had very little resemblance to the baby once fantasized. Rose wistfully remarked that she had hoped to see some family resemblance. I gently encased the baby's head in my hands, molding as much as possible to create some facial symmetry. Rose suddenly responded with a cry of delight, "Yes, there is a resemblance. She looks like John! Oh yes, I can tell this is our baby!" Then she held her hands out and asked if she could touch the baby in the same way. Gently she explored the baby with her fingertips. Finally she wrapped the baby in the blanket, held her close for a moment and then with a peaceful look said, "Thank you nurse, this has meant so much to me. You see, I never saw my first baby."

Rose has since corresponded with me. It appears that she has completed her grief work. Hopefully this experience has helped her to resolve her grief for the first child. Rose, because of her prior knowledge of the intrauterine death, had gone through some anticipatory grief, and some of the tasks of mourning may already have been completed prior to delivery.

Anticipatory grief can also mean that the relatives are prepared. The nurse needs to be sensitive to the family that has become so well prepared that its members might not be as supportive of the mother at the time of delivery as would be expected. Sometimes the mother in an attempt to deny reality may stop investing in a relationship with the baby prior to birth, feeling that she has suffered enough and will have nothing to do with the baby. She may blame the baby for the stress and painful procedures and then feel guilty about the resentment. Unless she understands that this is a normal reaction, her grieving may be impeded.

Touching and looking "symbolically helps to close the mystic gap between life and death more realistically, although at times more harshly, if the baby is disfigured."<sup>13</sup> This is especially true if the parents are unable to view the baby until after an autopsy has taken place. Preparation in this instance is extremely important.

Mothers or parents of the spontaneously aborted fetus may also have a need to view the fetus. The need will obviously be dependent on the length of the pregnancy and the usual variables. I realize there may be a degree of impracticality in my suggestion; my gynecological nursing colleagues inform me that in the majority of abortions the mothers show very little curiosity or any interest in seeing the fetus. I suspect that for some mothers, further exploration as to their feelings would have revealed a need for imagery.

*Sylvia and Charles were parents of a 16 week fetus delivered in the obstetrical unit following which Sylvia appeared to be coping reasonably well. However, 24 hours after the abortion Charles asked to speak to me. He said that he and his wife were really distressed about the loss of the baby and he wanted to know how he could help his wife who was having great difficulty talking about the situation. I spent some time with both of them. Sylvia eventually broke down, saying, "I've lost a baby — just because it was only a few weeks developed doesn't mean it wasn't a baby. It doesn't even get buried! I think of him as my baby, I've even given him a name — after his grandfather." I asked Sylvia and Charles if it would be helpful for them to have a brief memorial service for the baby. They expressed interest in this, and following a visit by the chaplain of the hospital, the four of us attended a service in the hospital chapel prior to Sylvia's discharge. Both parents expressed relief and gratitude for this opportunity; their grief work was facilitated by this acknowledgement of Bobby as an individual human being.*



### Placing loss within a spiritual and religious context

Placing the loss of the baby within a spiritual and religious context in keeping with the individual beliefs of the parents also facilitates the grieving process. It is well known that supportive interpersonal interaction takes place during religious mourning practices and the funeral itself is another means of assisting the bereaved to let go. The funeral meets often very personal needs and at the same time may represent the religious beliefs of the deceased and the family. "The funeral is not only a declaration of a death that has occurred, but it is also a testimony of a life that has been lived."<sup>14</sup> In my experience, however, some bereaved mothers have experienced further distress by not being able to be present at a burial service for the baby.

**Angela, who gave birth to a male child that lived for only a few minutes, was asleep during the birth. She was severely hypertensive and under sedation and had very little recall of the events surrounding the delivery. Two days later she asked to be discharged from the hospital in order to attend a burial service for her baby; in fact, she threatened to discharge herself if not given permission. Despite the persistent hypertension, the physician understanding Angela's need, temporarily released her from the hospital. Angela understood the risk she was taking, but for her the need to face the reality of losing her baby took priority over her own health. In her own way, however, Angela was looking after her health!**

### The memorial service

Evaluating the effectiveness of the current support system for bereaved parents within my hospital led to my sharing some concerns with the Director of Pastoral Care. We reviewed local funeral practices, became more aware of the flexibility of services, learned about alternatives for those for whom burial of the baby meant economic hardship, and became more organized in our plan to help parents with special needs; for example, we advised parents who wished to bury the baby without the services of the undertaker, directed parents in transportation of the body according to provincial requirements, and so on. We also offer parents and other family, including siblings, an opportunity to participate in a memorial service held in the hospital chapel.

Awareness of the philosophy of life held by the parents is essential as their attitude toward death will follow closely their feelings about life. In our hospital the nurses and Pastoral Care worker share information in the interest of planning the best approach for the bereaved. The parents are made aware of the availability of a memorial service and in no way are pressured to make a decision at first conversation. The service may be conducted by the family's own minister or priest or by the hospital Chaplain or a Sister from the Pastoral Care Department. A memorial service differs from a funeral service in that it is acknowledgement after death, without the body present. Not all parents choose a memorial service but those who have are unanimous in their comments that the service is helpful and had special meaning for them. One family asked instead that the nurse pray with them at the bedside. Regardless of the location or format of the service, some positive things can come about for the mourners and staff attending the memorial service.

The service itself can be of therapeutic value as it recognizes the grief of the parents and helps them to experience the grief together and in the presence of other supportive individuals. It can help to prevent pathological denial and later difficulties by helping the parents to openly face the reality of the loss. It can be a significant point in the letting go process. Not only is the mother able to be present, but she is able to receive physical support from the nurse if she becomes weak or ill. There is no cost factor involved for the parents. In addition the memorial service provides an opportunity for the staff to share in more than just physical and emotional care; it helps them to place their own sense of loss in a religious and spiritual context.

As inner acceptance is considered a very positive and constructive stage in the process of mourning,<sup>15</sup> the memorial service can be an effective means by which the bereaved are able to face the reality of death, accept it and then move on into resolution of grief. The service offers an opportunity for the family to be sustained through the expression of their religious faith and an acceptable setting within which they can let out their feelings. Finally, it provides a means by which the hospital staff can convey to the family their belief in the worth and dignity of the human person and indeed a reflection of the value we place on life itself. ♡

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# When experience counts

Sylvia Segal

*21-year-old Francesca whose mother tongue is Italian, was upset: her two-day-old son was very sleepy and wouldn't wake up for his feeding. Everyone seemed so busy and her English was not very good. She wished her mother were here to help. Why was she having so much trouble? Was there something wrong? Maybe she didn't have any milk and the baby was starving?*

*33-year-old Mrs. P. didn't know how she was going to cope; she felt so ridiculous asking the same questions over and over again. The nurses reassured her this was normal and she shouldn't worry about it, but how could she be such a scatterbrain? Why was she having so much trouble? Breastfeeding seemed so natural when they discussed it in prenatal classes, and she had read the recommended books. But now tears rolled from her eyes as she gazed at her hard, aching breasts and watched her screaming three-day-old daughter trying to grasp the nipple. She winced with pain as the baby finally got hold, and thought, "Is it really worth it?"*

*Mrs. J. was very anxious: she had lost two previous babies and now her premature daughter, Andrea, seemed so tiny and fragile. The doctor said Andrea was strong and healthy but Mrs. J. wished the nurses could stay with her until she finished her bottle. The nurse told her to burp the baby after every half ounce, but it was difficult to tell when half an ounce had gone. Andrea always seemed to gulp her bottle so quickly and then she seemed to spit most of it back up. Would she ever be alright?*

Helping new mothers sort out their questions and problems is easier when you've been there yourself. That's one reason why, in our hospital, we have come to depend on specially trained volunteers to bolster the support that nurses on the obstetrical unit are able to provide to patients.

York Finch General Hospital (300 beds, 38 OB) in Toronto is like hospitals everywhere these days — a victim of increased consumer demands and spiralling costs. Staff freezes and cutbacks are making it increasingly difficult for nurses to devote as much time as they would like to patient education.



The charge nurse takes time out to discuss patient problems with a volunteer.

It was three years ago that I approached the director of volunteer services, Elsa Ann Lee, about the possibility of initiating a volunteer program for new mothers. As coordinator of obstetrics, I wished to maintain our unit's family-centered approach with its relaxed and flexible schedule that made demand feeding possible. We both could see the advantages of an in-hospital, one-to-one counseling program on infant feeding practices by trained volunteers.

As a pilot project, we trained one volunteer who introduced the service to some of the mothers in hospital at the time. The program was an overnight success: soon we had volunteers working on the OB Unit every weekday, responding to the needs and concerns of our new mothers.

## Duties

The volunteers taking part in this program are expected to:

- support and encourage mothers in their infant feeding practices by assisting and counseling them about minor breastfeeding and bottle feeding problems as they occur in hospital.
- sell articles such as nursing bras, nighties and books on breastfeeding and child care (Maturnisales, we call them). Articles and books for sale have been suggested by the nursing and medical staff. The exchange provides a good opportunity for teaching and there is more stress on teaching than on making a sale.
- assist nurses with discharges by helping the patients gather their belongings together and escort the family to the hospital door.

## Selection

Volunteers are interviewed and selected by the Director of Volunteer Services. A subjective evaluation by the interviewer is made regarding attitude toward breastfeeding, modern feeding practices and childrearing. Successful candidates are expected to have a positive, "family-centered", outlook; other characteristics we look for are those of any volunteer: a caring attitude and a friendly, outgoing personality. Facility in a second language has also proved a definite asset at York Finch which serves a multi-cultural population.

## Training

Before being allowed to counsel on her own, each volunteer has to complete a training period which includes the following:

1. the concept of family-centered care
2. the philosophy of the obstetrical unit
3. hand washing technique and general hygiene
4. infection control theory and practices
5. process of lactation
6. common breastfeeding problems encountered in hospital and how to deal with them
7. common bottle feeding problems encountered in hospital and how to deal with them
8. discharge procedure — the limitations of the volunteer.

Each volunteer must also complete six on-the-job training sessions with a trained volunteer. At the end of the training period, each volunteer completes a written take-home examination, and is evaluated by her trainer and by the programs's nursing consultant.



### On the job

Volunteers wear a rose-color dress uniform while on duty; these uniforms, which can be purchased or rented, must be laundered or dry cleaned before each day's shift begins. A lab coat, supplied by the Volunteer Department, is worn over the uniform whenever the volunteer is off the unit.

All volunteers are required to have an annual chest x-ray or TB skin test provided by the hospital.

Each volunteer is assigned to a specific shift — 9:00 a.m. to 11:30 a.m. or 1:00 p.m. to 3:00 p.m. — and is responsible for notifying the unit and the Volunteer Department if she is unable to report for her shift. Replacements are obtained by either the volunteer who is unable to work or the program convenor. Not surprisingly, the Summer months are the most difficult to ensure full staffing.

As the program evolved, a daily routine was developed by the volunteers and hospital staff; these routines are checked annually and revisions made as needed. Good communication is the key to the success of the program and this aspect of the work is stressed in all our activities.

Volunteers check with the team control center for any "problem notes" left by the general nursing staff in an envelope provided for this purpose. The charge nurse of Postpartum or Nursery Departments is then contacted (or Team Leaders in their absence) for a report on any other problems. The first visits of the shift are with mothers reporting problems or mothers requesting supplies from Maturisales. If time permits, the volunteer then systematically visits as many patients as possible, telling them about the service, asking if there were any problems or questions, and showing them Maturisale supplies. Notes are left for the afternoon or following day volunteer to ensure further follow-up of problems and to identify how many patients were visited that shift.

### Ongoing training

Every six or eight weeks we schedule meetings on topics related to breastfeeding and modern infant feeding and care practices. A volunteer must attend two out of three of these sessions to remain active on the service. Listening, communication skills, consistency and recognizing the limitations of the volunteer role are stressed during these discussions and ongoing training. Volunteers were actively involved in developing the original program and continue to have say in its direction.



A volunteer from Maturisales helps a patient choose a nursing bra.

If an active volunteer is off the service for three months or longer she must again attend on-the-job training sessions and be re-evaluated before counseling on her own again.

### Evaluation

For the patients, the service means an interested, caring, empathetic "experienced mother" who has that extra time to listen and help.

For the nurses, the service provides a well-informed co-worker who can be trusted to give much needed support and accurate information to an anxious mother.

For the volunteer, the service provides the opportunity to offer help, to keep up-to-date on modern infant feeding practices and care, and also to develop her problem-solving and counseling skills. The service has also helped to create a positive encouraging atmosphere toward breastfeeding which is very evident on the unit; much of the volunteer's time is taken counseling and supporting the breastfeeding mother.

Obstetrical units, I'm sure, are not the only areas of the hospital where volunteers could provide services. Each hospital needs to examine its own situation and needs. Our program owes much of its success to the enthusiasm of its volunteers whose interest, in turn, is maintained by keeping them active in their service. Programs such as ours could not exist without the support and guidance of the nursing staff. Someone on the unit must take the interest and the time to motivate the volunteers and keep them up-to-date in their theory and practice knowledge.

Today there is a good deal of consumer pressure for greater flexibility on obstetrical units. I hope that our example will encourage other hospitals to open their doors to volunteers, since these programs provide an excellent opportunity for hospitals to bring a bit of the "home touch" atmosphere to their environment. ♡

*Author Sylvia Segal graduated from the University of Alberta in Edmonton, Alberta, in 1964. She has experience in armed service, public health, teaching, prenatal education and general duty nursing. Much of her teaching and practical experience has been in the field of obstetrics.*

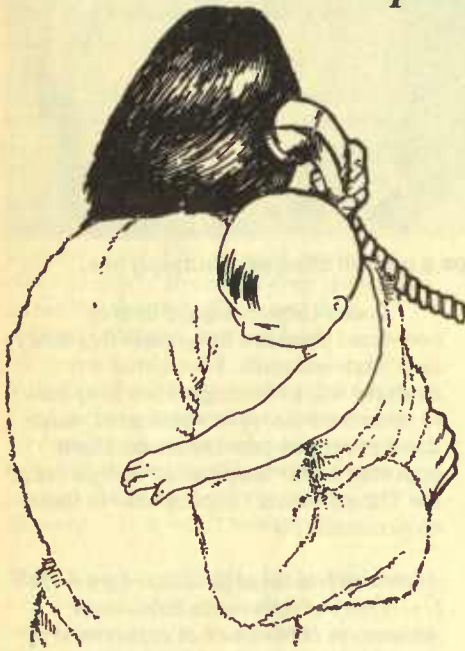
*At the time the program she describes in this article was set up, she was Coordinator of Obstetrics and Gynecology at York Finch General Hospital in Toronto. Segal is married and has two boys. She retired from full-time duty in the summer of 1978 but continues to provide training and guidance for the volunteers at York Finch.*

**Acknowledgement:** *The author wishes to acknowledge the contribution of Elsa Ann Lee, Sheila McKewen, Willy Wallis, Pat Thorburn and Helen Fronzak, whose enthusiasm and support of the program since its conception motivated her to write the article.*



# A postpartum program that really works

*Help for new mothers is as near as the phone in this small community in north central B.C.*



Kathleen Freeman

How could six community nurses, each already as busy as the next with immunization schedules, pre-school health assessments, long term care for senior citizens and home care for convalescents, possibly take on close to 500 new family units annually without seriously compromising the care they were expected to give?

What is the most efficient and effective way of making sure that new mothers get the help they need *when* they need it — the crucial days and weeks immediately following delivery?

How can postnatal problems be spotted and solved *before* they reach crisis proportions?

How can nurses serving a scattered rural community keep non-productive "travel time" to a minimum?

These were some of the questions that our office of the regional health unit was faced with five years ago. Our search for the answers, which continues to this day, took into account two major considerations:

- our unique demographic situation as a small town (pop. 23,000, including the surrounding area) about half way up the BCR railway line that links Vancouver to Fort Nelson, B.C.
- our philosophy and objectives which might be summed up by the belief that knowledge, to be preventive, must be available *before*, or at least at the time that it is needed.

## The problem

Before we could begin to find answers to the questions that confronted us, we had to define the dimensions of our problem. As a preliminary step, we undertook the development of a profile of community needs and trends based on demographic data that we assembled ourselves. At first, the only statistics we had were those relating to the number of births and school entrances. Then, from the census, we obtained more information about the various age groups in the area; a survey by the provincial department of economics on local industry gave us information about occupational characteristics. Once this method of planning was used successfully, each application to additional programs became easier. Through yearly updating and the addition of demographic data, as it became available, we soon had a fairly comprehensive profile of community needs and trends.

When we looked at this profile, we saw a steady influx of young couples into Quesnel to work in local industry, balanced by a steady outflow of families after the wage-earner gained more experience and higher qualifications. During the time these young couples were living in Quesnel, they would begin their families; in the community there were about 450 births per year. This number could be expected to remain constant or even to rise slowly. If we continued our present system of home visits, this would mean at least 450 hours of contact time, plus 200 hours of travel



time, just for initial home visits each year. Due to the high number of births and the system for referral, home visits were often made when the infants were three or four weeks old, after many crises had already passed.

## Our objectives

In a rural area such as ours, where there is no routine physician follow-up until six weeks postpartum, the role of the community health nurse is very significant. Thinking about this role and our new program, we reiterated as a group some of our fundamental beliefs about the philosophy of community health nursing. We believe in prevention. We believe that people need a variety of types of support and that they are capable of choosing and using the type of support that best fits themselves as individuals. Also, a maximum amount of nursing time should be available to counsel high risk families.



Keeping these considerations in mind, we drafted our objectives for the postnatal program as follows:

- to have contact with every mother giving birth prior to discharge from hospital, and again one week after discharge.
- to provide each mother with information regarding maternal and child care, enabling her to function effectively at home with a young infant.
- to identify as early as possible any mothers and/or infants who are at risk of developing problems.
- to use the most efficient and effective methods of meeting the needs of both high risk and "normal" mothers and infants.
- to provide an ongoing, easily utilized resource where information and group support are available to mothers as needed.
- to obtain feedback on the usefulness of the postnatal program through parental assessment and formal evaluation.

#### The tools

The postnatal program that we developed in response to these needs consisted of four distinct elements. These are, in the order in which we make them available to most families:

1. In-hospital classes
2. A telephone check six to ten days postpartum
3. New infant classes at the Health Unit
4. Home visits

*1. In-hospital classes* — The first line of support for the mother is knowledge of a newborn's needs and behavior and of the maternal changes postnatally. To provide this knowledge to every mother in the most efficient method, we arranged with the local hospital to conduct classes on the maternity floor twice a week just before lunch. This time was made available through the

cooperation of OB nursing staff and the physio department which reduced daily postpartum exercises to three times a week to accommodate our classes.

Studies have shown that maximum learning takes place at the time of crisis and need and, for this reason, the hospital stay provides a highly appropriate learning situation. Postpartum mothers can be gathered together as a group using a ward or lounge as meeting place. The C.H.N. uses a combination of discussion and didactic instruction to present information concerning the care of a newborn baby and the needs of a mother after discharge. The group setting makes it easy for mothers to ask questions, share concerns and obtain support from one another. Further reinforcement of learning takes place if mothers discuss class content afterwards.

Prior to the classes, mothers complete cards providing us with information on the family, prenatal class attendance and method of feeding. Problems that arose during the pregnancy or factors that might indicate risk are filled in by the C.H.N. before she returns the cards to the health unit. These cards help our nursing staff plan the appropriate follow-up contact with the mother; clerical staff use them to prepare agency records, and they are used as part of the program evaluation. During the class, mothers are given a folder containing a collection of pamphlets that they can read now and keep for future reference, (see Box).



The staff of the Quesnel Branch of the Cariboo Health Unit (left to right): author Kay Freeman, Marilyn Hurrell, Susan Brown, Terry Stevenson, Mary Gradnitzer and Eileen Kosior. Former staffer, Debra Little, who was since moved to Kelowna, is missing from the photo.

## Resource material postpartum classes

1. Planned Parenthood Federation of Canada. **Birth control that works.**
2. British Columbia. Ministry of Health. **Your public health services.**
3. International Childbirth Education Assoc. **Instructions for nursing your baby.**
4. Johnson & Johnson. **Baths and babies.**
5. British Columbia. Ministry of Health. **Common variations in the newborn.** CHU #16.
6. British Columbia. Ministry of Health. **Infant feeding.**
7. British Columbia. Ministry of Health. **Blender baby foods.** CHU #16.
8. G.R. Baker Memorial Hospital. **Diet for nursing mothers.**
9. Infant food guide. B.C. Diet Manual 1976.

During the classes, we actively encourage all the mothers to call the health unit if they have questions or problems after discharge, and invite them also to attend our new infant classes at the health unit. These postpartum classes take approximately two hours of nursing time a week.

*2. Telephone check* — The majority of mothers in Quesnel are discharged on the fourth or fifth day postpartum. Between the sixth and tenth day, we make a "phone visit" to all mothers with telephones during which we enquire as to how the mother and baby are doing. Initially, we use open-ended questions. If the mother's responses remain general, we proceed to more specific questions such as condition of the cord, feeding and sleeping patterns and the amount of rest the mother is obtaining. This allows us to counsel appropriately and to offer a home visit if problems indicate a need. We find, however, that the majority of mothers are coping well at the time of the initial phone call.

Mothers are again invited to bring their infants to the new infant classes or to contact the health unit if new problems arise. Phone calls generally take about ten minutes each. If the family has no phone, C.H.N.'s decide on the basis of risk whether to make a home visit or to send a personal note inviting the mother to come to the new infant classes.

*3. New infant classes* — When the mothers arrive at a new infant class, they are greeted by a volunteer who obtains records from the clerk, escorts each mother to the class and introduces her to the others. Frequently mothers have been in the hospital at the same time or in prenatal classes together and have an interest in each other.



The first ten or 15 minutes of each class is devoted to review care of the infant and mother in the postpartum period. This allows us to discuss the materials we would normally present during a home visit. Following this, we offer a short talk on some aspect of preventive health care lasting from ten to 15 minutes. Topics currently rotated are:

- baby's nutrition
- exercises with baby
- safety through the eyes of a child
- toys for baby
- baby's sleep patterns

Mothers identify with these topics, which reflect anticipatory guidance into growth and development of the infant, and the discussion is usually lively.

After this discussion, babies are weighed and each mother has the opportunity to discuss individually any concern she may have been hesitant to bring before the group. Some mothers return for all five of the discussion topics. Others come only once for reassurance. New infant classes take about one and a half hours of C.H.N. time per session.

Sometimes during discussion of topics or individual discussion, the C.H.N. will find a mother or infant who needs ongoing service: often the mother is cognizant of the difficulties but doesn't know where or how to obtain help. Other mothers, through lack of knowledge of growth and development, do not perceive potential problems. These families are referred to the district C.H.N. for further individual follow-up.

**4. Home visits** — Home visits are made in the traditional manner to high risk mothers and those whose telephone conversations reflect definite problems. The difference between the old and new system lies in the fact that those needing this type of service now receive it promptly; the C.H.N. arrives at the home more prepared for the specific situation, at a time when the mother is wanting to learn. Further follow-up may be through additional home visits, new infant classes or phone calls.

### The results

Before we arrived at the format we are now using, we conducted an informal evaluation of each new infant class during the initial shakedown session. We also tried to obtain written consumer feedback but with poor results; we did receive positive feedback verbally and the increased utilization of the program speaks for itself.

The first formal evaluation of the program took place six months after it was initiated and input from all nurses concerned was obtained. We found that, during the first six months, 79 per cent of the mothers in the hospital had attended postpartum classes, and 31 per cent of mothers had attended the new infant classes.

One of the reasons for not reaching our objective of 100 per cent contact with mothers in the hospital is that classes are held only on Tuesdays and Thursdays with the result that some mothers are not able to attend. We have not been able to arrange optimum spacing as yet, due to workloads of hospital and health unit staff. The ongoing communication between hospital staff and ourselves about improving the effectiveness of the classes, has promoted an important feeling of mutuality in providing care to new families.

Many mothers who wanted to attend the new infant classes could not make it at the time scheduled so we began to have classes on a weekly basis which helped overcome this problem.

Our evaluation indicated the need for a system of tabulating telephone calls with home visits and a form was designed and implemented to meet this need. We also recognized the need to standardize prioritization of high risk criteria and have been collecting information regarding various systems of identifying high risk, but have not yet worked through our own standardization: each nurse still has to use her own judgment.

The results of our second formal evaluation, which took place after the program had been in effect for 18 months, indicated that:

- the number of mothers attending postpartum classes had increased from 79 to 81 per cent of those eligible.
- we were able to reach 90 per cent of new mothers by telephone.
- almost one quarter (23 per cent) of these mothers were experiencing difficulties that warranted a home visit.
- 38 per cent of new mothers attended at least one new infant class; the average number of classes attended was three.
- three-quarters of those attending classes had concerns which, if they had not been dealt with in class, would have necessitated a home visit.

These results have left us feeling very positive about our program even though we know that we have not yet succeeded in reaching all of our goals. The steps that we have taken since then are:

- to institute monthly meetings between maternity nurses and C.H.N.'s promoting understanding and continuity and resulting, eventually, in improved service in both community and hospital.

**Table One**  
**New infant problems**  
**observed in classes**

Problem	Percent
Feeding difficulties	26
Rashes	16
Inadequate weight gain	10
Acute illness	10
Jaundice	7
Eye discharge	6
Other	25

N = 119

—to request a summer student to update and prepare more attractive educational materials for both postpartum and new infant classes.

—to continue to work on a priority system that will allow better identification of risk factors.

We estimate that implementation of our new program has saved approximately 200 hours of nursing time each year that it has been in operation. The services we have been able to provide under it have been at least equal to, if not better than, those that were previously available; high risk mothers and babies, in particular, have benefited from the program. In short, we feel that through our postpartum program we have found an innovative way of utilizing our resources for the benefit of the community as a whole. ☛

**About the author** — *Kathleen Nicely Freeman, RN, BS, is one of six community health nurses working out of Quesnel branch office of the Cariboo Health Unit in British Columbia. This article, "A postpartum program that really works", was written with the assistance of all of the Quesnel CHN's who participated in the design and development of the program.*

*Kay is a graduate of St. Anthony's School of Nursing and of the University of Oregon. She has been involved in community health nursing in a variety of positions, including teaching and administration in Canada and the US.*



# INSTITUTIONALIZATION

## What happens to patients in a long term treatment center

Barbara Haynes

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The Canadian Nurse

The fact that a hospital is an institution which serves large numbers of people in what is, for the most part, an orderly and efficient fashion is beneficial to the community-at-large. However, when people are in hospital for an extended period of time, perhaps for the rest of their life, the goals of rehabilitation and personal independence are often hindered by certain of the institutional aspects of that hospital or chronic care facility.

The sociological definition of an institution is "an organized system of social relationships that embodies certain common values and procedures and meets certain basic needs of society."<sup>1</sup>

When applied to a hospital, one can see that the common goals or values of the people who work in that institution are the cure of illness and the return of patients to a level of functioning at least as high as before their admission. To meet these goals as efficiently as possible, hospitals regulate activities by developing specific policies or routines for procedures which are applicable to all

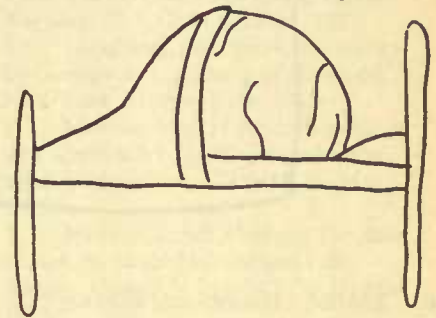
situations occurring within that institution. This includes not only diagnostic tests but also nursing procedures such as dressing changes, catheterizations and even bowel routines.

In other words, the institution requires the simplification of actions — the organization of human behavior into a harmonious pattern. The result is that all individuals connected with the institution become used or conditioned to these patterns or routines. The longer the association — in the patient's case, his hospital stay — the greater the degree of conditioning.

Why? Part of the reason is that patients are not as physically active as they would be normally, nor are they required to use their individual personalities and intelligence to make decisions and solve problems within the highly regulated atmosphere of the institution.<sup>2</sup> The institution takes over many of the individual's former functions.

Institutionalization then "involves the replacement of behavior that is spontaneous with behavior that is expected, patterned, regular and predictable."<sup>3</sup>

### THE GALLBLADDER IN 69



The process of institutionalization does serve a function: the "processing" of large numbers of people in an efficient fashion. At the same time, it may have a detrimental effect, in that it works against the long term rehabilitation of dependent patients and may even have a negative effect on hospital staff.

### The pattern takes shape

Factors promoting institutionalization range from the simple physical realities to the more complex issue of human behavior. Physical characteristics of a hospital ward include uniform decor and a generally limited environment. An important factor too is the rigid daily ward routine of fixed times for meals, medications, bathing and bedmaking.

However, it is agreed that in the interest of practicality and patient safety, many of these physical realities cannot be changed, and for the short term patient they do not matter that much. In a large hospital with a central kitchen for instance, meals have to be mass produced for distribution at specific times; similarly, it is easier and safer to fix times for medications to be given so that time is not wasted and medications are not forgotten.

It is the more important factor of human interaction that in fact makes the process of institutionalization a negative one for the long term patient.





What behavior then, especially on the part of nurses, contributes specifically to the dehumanization of patients during institutionalization? At least four attitudes have been found to have a profound psychological effect on patients:\*

where a nurse feels uncomfortable, such as when a patient is angry or sad. Because she is uncomfortable dealing with psychological needs, the nurse employs this method unconsciously to make ventilation of feelings difficult for

emotional problems effectively. Patients then see the staff as non-spontaneous, mechanical and generally preoccupied with the task at hand.

#### How the patients feel

"Without the little things — the smile or touch on the arm — the patient feels alone and afraid, and really no longer human."<sup>6</sup>

In a long term care or rehabilitation setting, emotional needs are great; patients are often depressed at facing a long hospital stay or perhaps a lifetime disability. Ignoring these emotional needs may result in decreased motivation in patients, lessened performance and longer hospital stays.

Basically, the problem is one of loss of control. A patient is no longer free to choose what to eat or when to eat it (or even whether to eat at all), his daily schedule is plotted for him, privacy is negligible and noise levels tension-provoking and distracting. In many ways, the person in hospital is forced to regress and to relinquish the personal independence and control over life that he has been handling for years. He may exhibit behavior indicative of the stress that he is experiencing, for example, excessive complaining, frequent and unusual demands, and refusal to comply with treatment or routines. All these are attempts to regain control; unfortunately, he risks being branded as a 'nuisance' who is 'uncooperative'.

In the case of the long term patient, the length of his stay within the institution usually results in compliance — "if you can't beat 'em, join 'em" — and there comes a characteristic

- *labelling*. Institutional workers often tend to classify or label patients, which serves to make the patient less than human for both himself and the staff; often after a label is applied, a less than human response is required for the labelled patient.
- *intellectualism*. Similar in a way to labelling, intellectualism is the focusing on a specific problem rather than a holistic look at the person with the problem. Mr. Jones becomes his gallbladder...or hip...or lumbar disc.
- *distancing*. Nurses may spend as little of their time as possible interacting with patients, preferring to give only the necessary physical care and no more.
- *humor*. While often useful as a safety valve for built-up tension, humorous remarks made at the expense of patients often ensure that staff members do not get seriously involved with their patients as people.

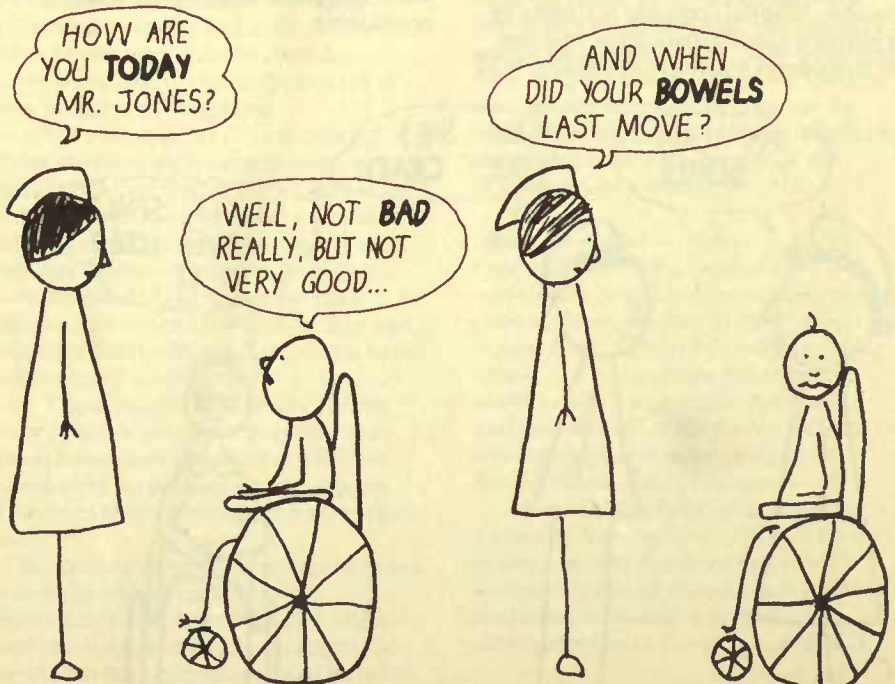
#### Communication

It is helpful too to look at the specific communication techniques used by nurses to examine how dehumanization of patients really occurs.<sup>4</sup>

One such style of communication can be described as *source-oriented*. People who use this style are generally concerned more with themselves than with others, and think predominately about how they are "coming across". This insecurity is manifested in several ways: superficial conversation, disjointed phrases or *non sequiturs*, use of exaggerated gestures and lack of direct eye contact. Source-oriented communication is common in situations

the patient. In a rehabilitation setting this is detrimental as unmet emotional needs can impede progress.

*Message-oriented* communications reveal a strong task orientation on the part of the staff member;<sup>5</sup> she believes that the patient's feelings have little relevance to the task to be accomplished, and shows little interest in how a message is received by a patient. This situation frequently occurs when nurses have a large workload to cope with, or when there is not time to handle





dependence, loss of clarity in thinking and a decline in physical functioning. Changes in routine cause upset and the suggestion of discharge may result in regression. The patients generally feel unable to care for themselves.<sup>7</sup>

The positive aspects of a strictly regulated atmosphere deserve mention: it is true that some elderly patients feel lost in a strange environment and a daily routine serves as a framework to keep them in the real world; younger patients too who perhaps have less maturity and self-discipline benefit from the limits imposed by a schedule agreed upon with their nurse.

Obviously, the only way to prevent the downgrading of individuals into inhuman uniformity is for each nurse to develop care plans around the special needs of each of her patients, in short, to treat them as individuals.

#### How to do it?

To prevent institutionalization, it is important basically to recognize the effects that certain factors within the hospital can have on patients, and to remain sensitive to them. Measures that promote individuality — dressing a patient in his own clothes when possible, for example — should be encouraged. Anything that helps to create a brighter, more stimulating environment will help. Control over and responsibility for bodily functions such as sleep and elimination should be returned to the patient, and his participation in rehabilitation goal setting should be encouraged.

Most important though, is the nurse's attitude to the patient and the realization that her priorities start with

the patient as an individual, not the institution. This basic principle prevents the occurrence of source- and message-oriented communication and encourages instead a type of communication which may be called receiver-oriented.<sup>8</sup> This style of communication recognizes the importance of the patient and his psycho-emotional needs; he is the "receiver" of the messages. The nurse who wishes to employ this type of communication to her patient's benefit must be an active listener; direct eye contact, physical proximity and the clarification of things not fully understood are all important.

Patients in hospital, especially those in long term facilities, need to know that they are not only cared for but cared about; only then can they return to a high level of wellness, both physically and mentally. Institutionalization is counter-productive, and if the nurse wishes truly to perform her role of patient advocate — not hospital advocate — she must be aware of the mechanics of this process. ♡

\*Source: Bakal, Donald A. *Psychology for the Health Sciences: an introduction*.

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\*Unable to verify in CNA Library

Barbara Haynes wrote this article while enrolled as a student at the Foothills Hospital School of Nursing in Calgary. Since graduating, she has been working at the United Church Hospital in Bella Bella, B.C.





# LEGIONNAIRE'S DISEASE

## An Old Enemy with a New Name

Erna J. Schilder

Since its first appearance in North American news headlines in 1976, Legionnaire's Disease has been regarded by the public as a mysterious and frightening killer. This nurse reviews medical literature to help dispel some of the mystique.

Three years after the first reported outbreak of Legionnaire's Disease, the disease is once again in the headlines. In August 1976, newspapers excited the public with reports of the existence of a mysterious and fatal disease. The news stories followed the development of the disease after the American Legion Convention held in Philadelphia, Pennsylvania, July 21st to 24th, 1976. Twenty-nine people died, and the mysterious pneumonia-like entity was named Legionnaire's Disease.<sup>1</sup>

Since that time, outbreaks of the same disease have been identified in other parts of the U.S. and Canada, most recently in Toronto. Just last Summer, *The Globe and Mail* reported on August 7, 1979 that 10 to 12 residents of Metropolitan Toronto were believed to have contracted Legionnaire's Disease; several of these cases were later confirmed.<sup>2</sup>

While it is true that not a great deal is known about this particular disease organism, Legionnaire's Disease is not quite as mysterious nor as terrifying as the newspapers make out.

### Etiology

*Legionella pneumophila* is the causative organism in Legionnaire's Disease; there are 4 sero-groups, and the symptoms manifested are as with any pneumonia, together with GI and CNS symptoms. The reservoir for the organism is not known; excavation sites are believed to be implicated and once, in Bloomington, Indiana when 19 people contracted the disease, the organism was cultured from water in a roof-top air conditioning unit. The bacteria is probably air-borne, and its incubation period is not known for certain but is possibly one to ten days.

It was in January 1977 that the Center for Disease Control in Atlanta Georgia announced it had discovered the organism.<sup>3</sup> Problems encountered in identifying the disease were due to the huge number of studies that had had to be done to rule out all other possibilities, before focusing on the search for a new causative organism.

Studies have found that legionella pneumophila grows slowly, in five to 10 days, when incubated at 35°C on chocolate agar plates, after being obtained from pleural fluid or lung tissue.<sup>4</sup> A more expedient means of establishing the diagnosis has since been developed: serum of an affected patient can now be tested for antibodies, and a definite diagnosis can be made if there is a rise in titre.

### Clinical manifestations

Two to 10 days after exposure to the organism, a patient may exhibit symptoms of malaise, myalgia and slight headache. Within 24 hours a high fever of 39°C to 41°C may develop associated with chills, dyspnea, and a non-productive cough. Other symptoms of chest pain, abdominal pain and GI disturbances may also be present. Many patients have rales on auscultation without other evidence of consolidation.

Laboratory findings include leukocytosis, proteinuria, an elevated ESR — greater than 80 mm/hr in most. In some patients there may also be hyponatremia, mild azotemia and elevated SGOT and alkaline phosphatase levels.

Chest x-rays commonly demonstrate unilateral involvement and pleural effusion; the one-sided lung consolidation rapidly expands into lobar involvement.<sup>5</sup> The disease usually worsens over the first two to three days; the cough becomes productive at this time, but the sputum is rarely purulent.

Although both sexes are susceptible, mortality due to Legionnaire's Disease is higher in male patients.<sup>6</sup> Gastrointestinal bleeding is frequently present, and the patient eventually succumbs to either shock, respiratory failure, or both. Renal failure has been reported in several patients and is probably secondary to the respiratory involvement. In patients who recover, improvement generally lags several days behind the evidence in x-rays.

The description of this disease might give one the impression that there is little difference between Legionnaire's Disease and the usual bacterial pneumonia. The distinguishing features of this disease, however, are high fever, non-productive cough, no micro-organisms cultured or seen in smears from sputum, leukocytosis, evidence of consolidation in chest x-rays, and — significantly — there is no response to the usual anti-microbial treatment for pneumonia.

Since the mortality rate currently rests at 15 per cent, a firm diagnosis at an early stage of the disease is of crucial importance in implementing appropriate therapy.

### Treatment

Medical treatment of Legionnaire's Disease is aimed at the relief of presenting symptoms and the prevention of complications.





Photo courtesy of Vancouver General Hospital

After several studies, researchers have concluded that erythromycin is the antibiotic that is currently most effective in treatment of this disease. Patients who do not respond well to erythromycin alone should receive a combination of erythromycin and rifampin.

Of particular importance in therapy is the maintenance of metabolic and fluid requirements to support the restorative processes in the acutely ill febrile patient. Respiratory care must be aimed at maintenance of adequate oxygenation, good tracheal-bronchial hygiene, and support of the dyspneic patient.

Nursing care of the patient with Legionnaire's Disease has two distinct goals: first is the promotion and maintenance of a comfortable and safe (i.e. hygienic) environment. Isolation is not necessary in the care of these patients, but steps must be taken to avoid secondary infection.

Second, observation of the patient is crucially important for the nurse. The patient must be observed for any change — marked restlessness associated with severe dyspnea and a respiratory rate of more than 40 per minute are signs that the partial oxygen tension ( $PO_2$ ) has fallen below 60 mm Hg in arterial blood. This must be prevented as respiratory failure and shock are the final outcome. Vital signs too should be closely monitored as they are indications of impairment of physiological function; intake and output measurements, evaluation of cough, noting the presence of pain, and monitoring laboratory findings are other important nursing functions.

#### Finding out

Contrary to the impression created by the press, Legionnaire's Disease is an old disease with a smart new name. It was simply one more unidentified killer, until 29 people died from it at once in 1976; it is thought that *Legionella pneumophila* affects an estimated 25,000 people a year in the U.S., 2500 in Canada, but most of the patients' diagnoses are only suspected, not confirmed.\*

Information about the disease is now available and it behooves the nursing profession to learn more about this old enemy. ♣

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**Erna Josefina Schilder, RN, BN, MA**, is currently an assistant professor at the University of Manitoba School of Nursing. She has a varied clinical experience, having worked in hospitals in Germany, Holland and England, and since in Canada has been involved in staff nursing, nursing administration and teaching in Manitoba.



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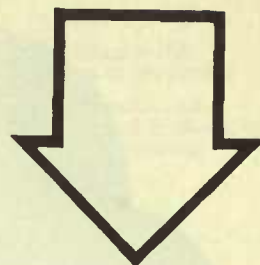
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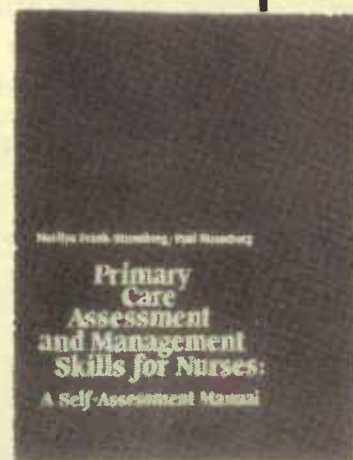
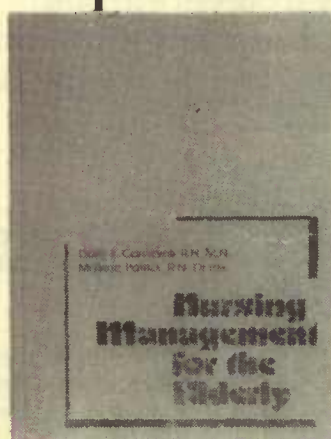
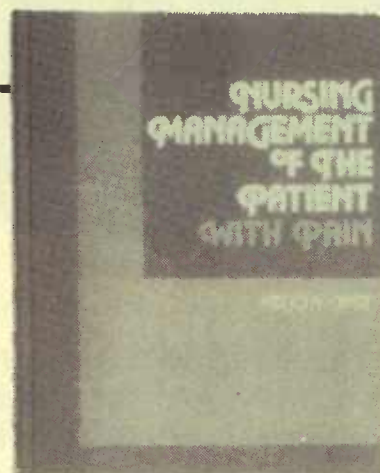
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**You and the law** (continued from page 16)  
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the law as it now stands, the state, through the instrumentality of the Courts, or otherwise, or the family, be its members parents, or in the case of the elderly, children, have the right to take upon themselves the subjective prerogative of altering irreversibly by medico-surgical procedures the lives of others who may, for whatever reason, be incapable of making that decision for themselves, in a manner which will deprive them of any of their faculties as human beings, other than for the preservation and protection of health, or the preservation and protection of quality of life. The law, as I see it, does not permit this to be done."<sup>11</sup> ♡

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"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author **Corinne L. Sklar** is a recent graduate of the University of Toronto Faculty of Law. Prior to entering law school, she obtained her BScN and MS degrees in nursing from the University of Toronto and University of Michigan.



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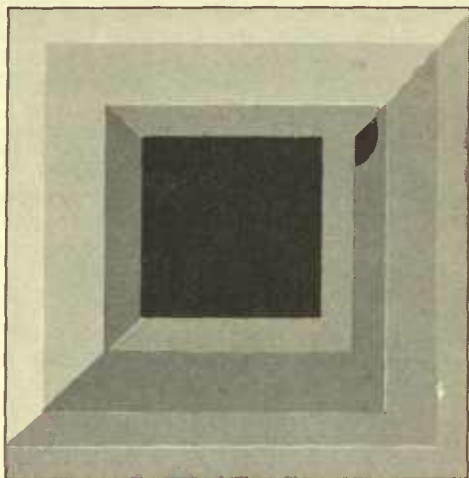
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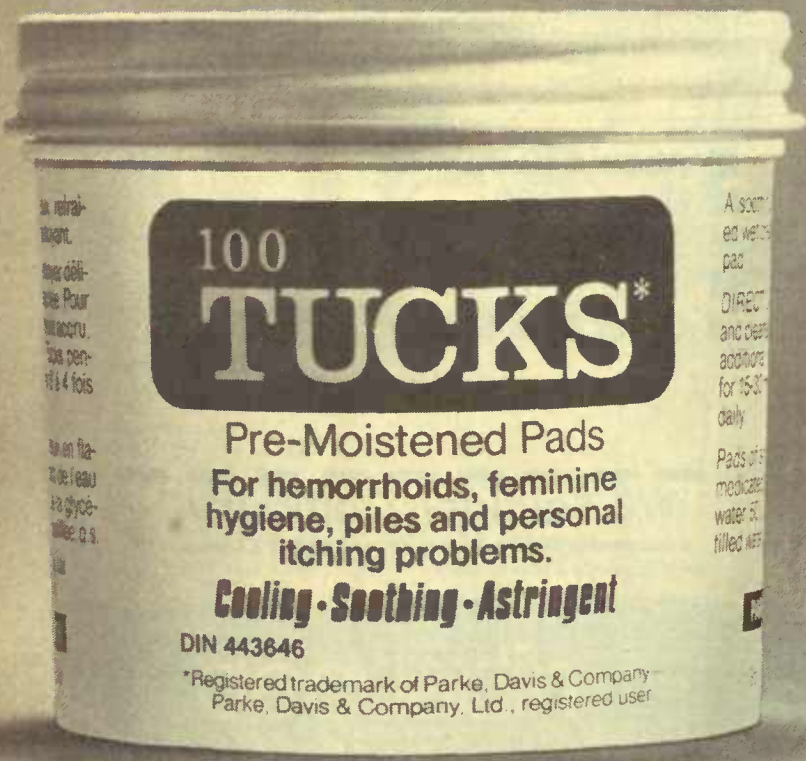
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When the beads are saturated (12 to 24 hours later) rinse and wipe them away. Apply a fresh layer of Debrisan.



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**An audio-visual presentation available on loan, free of charge**

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## Nursing Care

Nursing assessment and health promotion through the life span, by Ruth Beckmann Murray and Judith Proctor Zentner. 2d ed. Englewood Cliffs, N.J., Prentice-Hall, c1979. 448p.

## Obstetrics

The cesarean birth experience: a practical, comprehensive, and reassuring guide for parents and professionals, by Bonnie Donavan. Boston, Beacon, c1977. 240p.

## Occupational Health Nursing

Report on the feasibility of establishing a post-registration designation or certification program for occupational health nurses in Ontario by Ontario Occupational Health Nurses Association. Mississauga, Ont., c1979. 120p.

## Paediatrics

Care of the high risk neonate by Marshall H. Klaus and Avroy A. Fanaroff. Toronto, Saunders, 1979. 437p.

Child health maintenance; concepts in family-centered care by Peggy L. Chinn. 2d ed. Toronto, Mosby, 1979. 934p.

A healthy child, a sure future by the World Health Organization. Geneva, 1979.

## Pharmacology

Pharmacology and drug therapy in nursing by Morton J. Rodman and Dorothy W. Smith. 2d ed. Toronto, Lippincott, c1979. 1085p.

## Single-Parent Family

One in ten; the single parent in Canada, by Benjamin Schlesinger. Toronto, University of Toronto, 1979. 150p. 4

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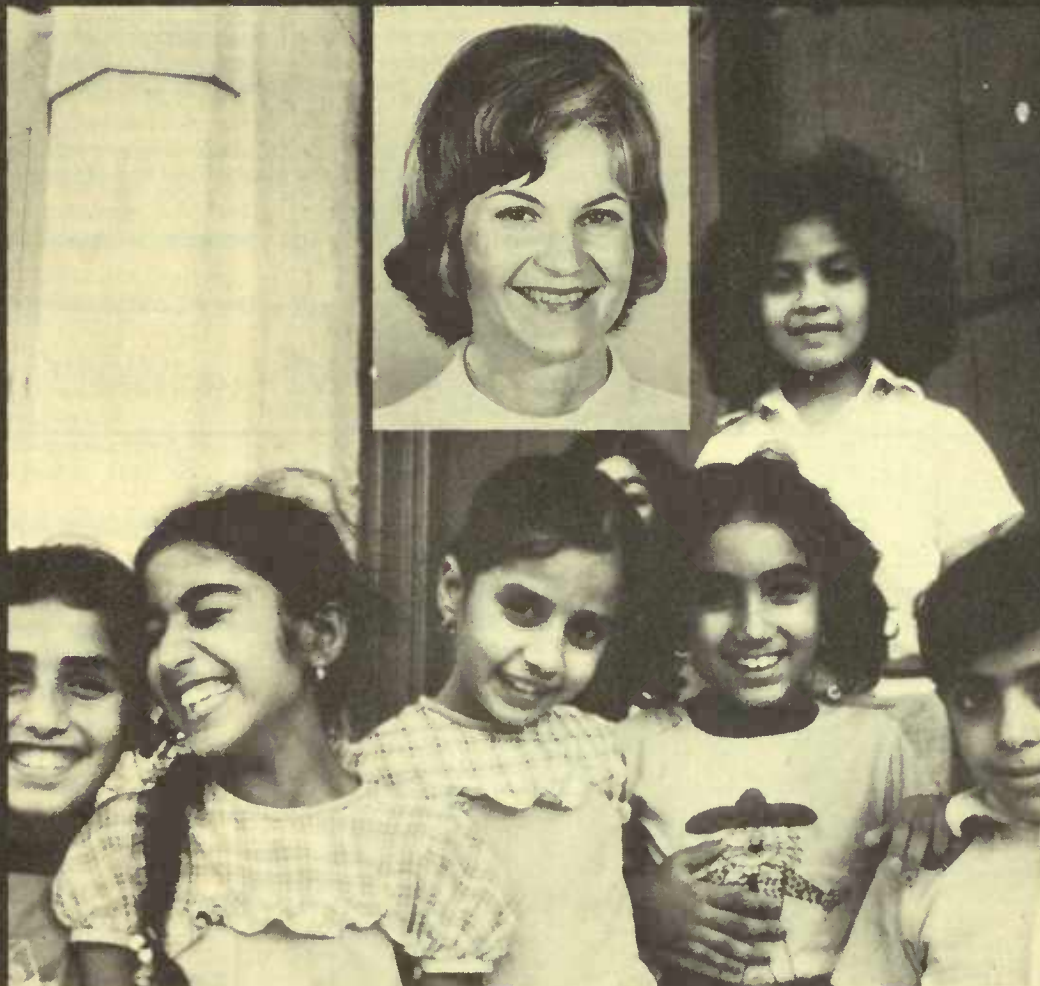
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**Registered Nurses** required for full time work on Medicine and Pediatrics as well as Surgery and Maternity. To work rotating shifts. Positions available immediately. Apply to: Director of Nursing, St. Joseph's General Hospital, P.O. Box 490, Vegreville, Alberta T0B 4L0. Phone: 1-403-632-2811.

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**Staff Nurses** required for the following areas: Psychiatry, Extended Care and Medical. Eligibility for Registration in B.C. required. Formal training and/or experience preferred. Apply in writing to: Director of Nursing, Matsqui-Sumas-Abbotsford General Hospital, 2179 McCallum Road, Abbotsford, British Columbia V2S 3P1. Phone: 853-2201.

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**Operating Room Head Nurse**—Must be RNABC registered. Must have experience in all O.R. procedures. Salary: according to the RNABC Agreement. Please apply in writing to: Mrs. A. Houghton, Director of Nursing, Fort St. John General Hospital, 9636—100th Avenue, Fort St. John, British Columbia V1J 1Y3.

**General Duty Nurses**—Must be registered with RNABC. Salary according to the RNABC Agreement. Please apply to: Mrs. A. Houghton, R.N., Director of Nursing, Fort St. John General Hospital, 9636—100th Avenue, Fort St. John, British Columbia V1J 1Y3.

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**General Duty Nurse** for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurse's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia, V0H 1H0.

**General Duty Registered Nurses** required for 108-bed accredited hospital in northwest B.C. Previous experience desirable. Salary as per RNABC Contract with northern allowance. For further information, please contact: Director of Nursing, Kitimat General Hospital, 899 Lahakas Blvd. N., Kitimat, British Columbia V8C 1E7.

**Permanent Part Time and Holiday Relief General Duty Registered Nurse** preferably with one year's experience including obstetrics and geriatrics. Salary, benefits as per RNABC contract. Small hospital in scenic West Kootenays—skiing, fishing, golfing, boating, hiking, swimming. Apply: Slokan Community Hospital and Health Care Society, Box 129, New Denver, British Columbia V0G 1S0.

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**General Duty RN's or Graduate Nurses** for 54-bed Extended Care Unit located six miles from Dawson Creek. Residence accommodation available. Salary and personnel policies according to RNABC. Apply: Director of Nursing, Pouce Coupe Community Hospital, Box 98, Pouce Coupe, British Columbia or call collect (604) 786-5791.

**Experienced General Duty Nurses** required for 130-bed hospital. Basic Salary \$1,305.00—\$1,542.00 per month. Policies in accordance with RNABC Contract. Residence accommodation available. Apply in writing to: Director of Nursing, Powell River General Hospital, 5871 Arbutus Avenue, Powell River, British Columbia V8A 4S3.

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**Four R.N.'s** urgently needed for 8 bed modern hospital in southern Sask. Must be eligible for S.R.N.A. registration. Please apply to: Administration, Beechy Union Hospital, Box 68, Beechy, Saskatchewan S0L 0C0 or Telephone (306) 859-2118.

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Our 23rd Year of World Wide Service

## United States

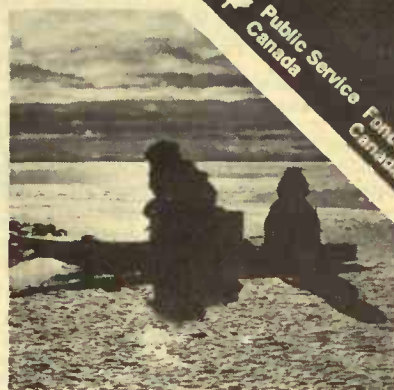
**California** — Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, ext. 1680.

## United States

**Florida Nursing Opportunities** — MRA is recruiting Registered Nurses and recent Graduates for hospital positions in cities such as Tampa, St. Petersburg, and Sarasota on the West Coast; Miami, Ft. Lauderdale and West Palm Beach on the East Coast. If you are considering a move to sunny Florida, contact our Nurse Recruiter for assistance in selecting the right hospital and city for you. We will provide complete Work Visa and State Licensure information and offer relocation hints. There is no placement fee to you. Write or call **Medical Recruiters of America, Inc.** (For West Coast) 1211 N. Westshore Blvd., Suite 205, Tampa, Fl. 33607 (813) 872-0202; (For East Coast) 800 N.W. 62nd St., Suite 510, Ft. Lauderdale, Fl. 33309 (305) 772-3680.

Nurses:  
Try Canada's  
Northland  
This Summer

Infirmières:  
Découvrez les  
Terres  
Septentrionales  
du Canada cet été.



Public Service  
Canada  
Fonction publique  
Canada

Join the team providing health care to the residents of the Northwest Territories. Medical Services, Northwest Territories Region will be offering a number of term positions for qualified and experienced nurses.

Positions are available at nursing stations, health centres and hospitals for the period, May through September.

Knowledge of the English language is essential.

For more information write to: Nursing Advisor, Human Resource Planning, Medical Services Branch, Health and Welfare Canada, Room 1972, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario K1A 0L3

*NOTE: Permanent positions are also available.*

Open to both men and women



Joignez-vous à l'équipe médicale qui soigne les habitants des Territoires du Nord-Ouest. La direction des Services médicaux, région des Territoires du Nord-Ouest, offre des postes d'infirmières diplômées, pour une période déterminée.

Les postes offerts se trouvent dans des postes de soins infirmiers, des centres sanitaires ou des hôpitaux; la période de travail va de mai à septembre.

La connaissance de l'anglais est indispensable.

Pour de plus amples renseignements, prière d'écrire à l'adresse suivante: Conseillère en soins infirmiers, planification des ressources humaines, Direction générale des services médicaux, Santé et Bien-être social Canada, Pièce 1972, Immeuble Jeanne Mance, Parc Tunney, Ottawa, Ontario K1A 0L3

*REMARQUE Des postes permanents sont également offerts.*

Appel de candidatures mixtes



Health and Welfare  
Canada

Santé et Bien-être social  
Canada

Canada



## Nursing in the Sunny Palm Beaches

Picture yourself in the sunny Palm Beaches working at the most prestigious hospital in Florida. Good Samaritan Hospital has maintained the tradition of being the first in the latest hospital services and facilities. Our good name and outstanding history attest to our success.

A 326 bed, J.C.A.H. accredited hospital offering attractive salaries and benefits including:

- Active in-service orientation
- Continuing educational programs
- 37 1/2 hour week
- 5 day week
- No shift rotation
- Education and experience differential
- Fully paid Blue Cross/Blue Shield
- Shift differential and other employee benefits
- Seasonal employment welcome
- Patient-mix 90% under age 65

We will sponsor the appropriate employment Visa for qualified applicants. Attractive efficiency apartments available at far below commercial rates, overlooking the beautiful Lake Worth and located across the boulevard from the hospital.

Write:

Director of Personnel (305) 655-5511  
Good Samaritan Hospital  
Flagler Drive at Palm Beach Lakes Blvd.  
P.O. Box 3166  
West Palm Beach, Fla. 33402



## Offers R.N.'s

An UNUSUAL OPPORTUNITY.

A.M.I. WILL FURNISH One Way AIRLINE TICKET to Texas and \$500 Initial LIVING EXPENSES on a Loan Basis. After One Year's Service, This Loan Will be Cancelled.

**AMI** American Medical International Inc.

HAS 50 HOSPITALS THROUGHOUT THE U.S.

\* Now A.M.I. is Recruiting R.N.'s for Hospitals in Texas. Immediate Openings. Salary Range \$11,000 to \$16,500 per Year.

\* You can enjoy nursing in General Medicine, Surgery, ICC, CCU, Pediatrics and Obstetrics

\* A.M.I. provides an excellent orientation program, in-service training



U.S. Nurse Recruiter

P.O. Box 17778, Los Angeles, Calif. 90017

\* Without obligation, please send me more information and an Application Form

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE ( ) \_\_\_\_\_  
LICENSES: \_\_\_\_\_  
SPECIALTY: \_\_\_\_\_  
YEAR GRADUATED: \_\_\_\_\_ STATE: \_\_\_\_\_

## United States

**Nurses—RNs—Immediate openings in California—Florida—Texas—Maryland—Virginia and many other States** — if you are experienced or a recent Graduate Nurse we can offer you positions with excellent salaries up to \$16,000 per year plus all benefits. Not only are there no fees to you whatsoever for placing you, but we also provide complete Visa and Licensure assistance at also no cost to you. Write immediately for our application even if there are other areas of the U.S. that you are interested in. We will call you upon receipt of your application in order to arrange for hospital interviews. You can call us collect if you are an RN who is licensed by examination in Canada or a recent graduate from any Canadian School of Nursing. Windsor Nurse Placement Service, P.O. Box 1133, Great Neck, New York 11023, (516) 487-2818.

"Our 23rd Year of World Wide Service"

**The Best Location in the Nation—The world-renowned Cleveland Clinic Hospital is a progressive, 1030-bed acute care teaching facility committed to excellence in patient care. Staff Nurse positions are currently available in several of our ICU's and 30 departmentalized medical/surgical and specialty divisions. Starting salary range is \$14,789 to \$17,056, plus \$1248/year ICU differential and premium shift differential, comprehensive employee benefits and an individualized 7 week orientation. We will sponsor the appropriate employment visa for qualified applicants. For further information contact: Director-Nurse Recruitment, The Cleveland Clinic Hospital, 9500 Euclid Avenue, Cleveland, Ohio 44106 (4 hours drive from Buffalo, N.Y.); or call collect 216-444-5865.**

**Come to Texas** — Baptist Hospital of Southeast Texas is a 400-bed growth oriented organization looking for a few good R.N.'s. We feel that we can offer you the challenge and opportunity to develop and continue your professional growth. We are located in Beaumont, a city of 150,000 with a small town atmosphere but the convenience of the large city. We're 30 minutes from the Gulf of Mexico and surrounded by beautiful trees and inland lakes. Baptist Hospital has a progress salary plan plus a liberal fringe package. We will provide your immigration paperwork cost plus airfare to relocate. For additional information, contact: Personnel Administration, Baptist Hospital of Southeast Texas, Inc., P.O. Drawer 1591, Beaumont, Texas 77704. An affirmative action employer.

**Nurses — RNs — A choice of locations with emphasis on the Sunbelt. You must be licensed by examination in Canada. We prepare Visa forms and provide assistance with licensure at no cost to you. Write for a free job market survey Or call collect (713) 789-1550. Marilyn Blaker, Medex, 5805 Richmond, Houston, Texas 77057. All fees employer paid.**

**Nurse — Midwives — Northern Africa & Central America:** Bachelor's Degree, Midwifery Certification, 5+ years' experience and an interest in clinical and classroom teaching. Project HOPE provides excellent benefits, travel, shipping and storage, salary commensurate with experience. Short and long term positions available. Send resume to: Personnel Department, Project HOPE, Millwood, Virginia 22646. E.O.E.

## Miscellaneous

**Adventure Holidays:** Camping Safaris, Overland Expeditions and Fun Experiences. We offer trips from one week to 3 months in: Canada, USA, Europe, Africa, Asia, South and Central America, Australia, New Zealand and the Caribbean. For free catalogue, apply to: Goway Travel, 53 Yonge St., Suite 101, Toronto, Ontario M5E 1J3. Phone: 416-863-0799. Telex: 06-219621.

**Electrolysis — Successful Electrolysis Practice for Sale.** 6 months specialized included. Write or phone: Margot Rivard, 1396 St. Catherine Street West, Suite 221, Montreal, Quebec, H3G 1P9. Telephone: (514) 861-1952.

## Brandon General Hospital School of Nursing Requires

### Program Co-ordinator

- July 7, 1980

### Teachers

- August 1, 1980

Applications are invited for these Faculty Positions in a Hospital based two-year diploma nursing program which uses an individualized teaching-learning approach.

Eligible for M.A.R.N. Registration, Bachelor's Degree in Nursing and a minimum of one year's clinical practice experience required for teacher positions.

Master's Degree in Nursing with appropriate experience in program planning, curriculum development and teaching preferred for Program Co-ordinator position.

Apply sending resume to:

Mrs. Shirley J. Paine  
Director of Nursing Education  
School of Nursing  
Brandon General Hospital  
150 McTavish Ave. E.  
Brandon, Manitoba  
R7A 2B3

## Head Nurse

### Neonatal Intensive Care Unit

The Victoria General Hospital, a 422-bed community hospital invites applications from B.C. Registered Nurses for the challenging position of Head Nurse — Neonatal Intensive Care Unit.

The hospital is currently involved in a total rebuilding programme and upon completion of the new facility in 1982 will be the major referral hospital for Obstetrics for the Victoria region.

Reporting to the Director of Patient Care Services, the Head Nurse assumes responsibility for patient care, staffing, and operating efficiency of the Unit. The Head Nurse, in cooperation with other Obstetrical staff, will also be involved in developing procedures, staffing requirements, etc. for the new facility.

Commitment to family-centered obstetrical care is essential. Post-graduate training in Neonatal Intensive Care or equivalent experience and demonstrated leadership ability required. Teaching experience an asset.

Apply to:

Personnel Manager  
Victoria General Hospital  
841 Fairfield Road  
Victoria, B.C.  
V8V 3B6



# THIS IS NO ORDINARY HOSPITAL . . .

*It's The Hospital of the Future!*

**Featuring:**

- FRIESEN CONCEPT
- NO NURSING STATIONS
- TOTAL NURSING SUPPORT from  
Central Supply - Pharmacy  
Dietary - Medical Records  
Laundry
- UNIQUE DESIGN CONCEPTS
- COMPUTERIZED SYSTEMS
- TOTAL PATIENT CARE
- PRIMARY NURSING

The emphasis is on NURSING at Holy Cross Hospital, a 259-bed acute care facility located just north of Los Angeles. Call us collect for full information on *The Hospital of the Future*.

Contact Marian Williams, Nurse Recruiter,  
at (213) 365-8051, ext. 1488

## Holy Cross Hospital

15031 Rinaldi Street  
Mission Hills, Ca. 91345

Equal Opportunity Employer M/F

## Exploring the Many Faces of Opportunity

Opportunity wears many faces at Santa Monica Hospital Medical Center in Southern California. It can be the excitement and challenge of working as part of our Operating Room or Critical Care teams. It can also be in the achievement of your goals as you begin to play a more active role in management and/or supervision.

However, opportunities expand beyond your professional life in Southern California. The total scope of the active life is virtually unlimited . . . from wide, sunny beaches to near-by winter slopes . . . the opportunities are here.

If you would like more information about exploring the many opportunities now available to you, please forward the below coupon. Who knows, you may find a new definition for "opportunity".



### Santa Monica Hospital Medical Center

1225 15th St., Santa Monica, CA 90404  
(213) 451-1511 Ext. 2537

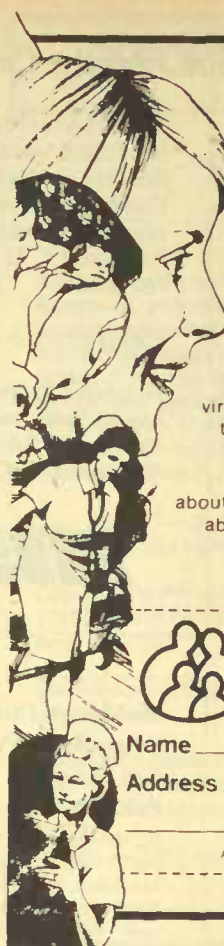
Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

An Equal Opportunity Employer M/F

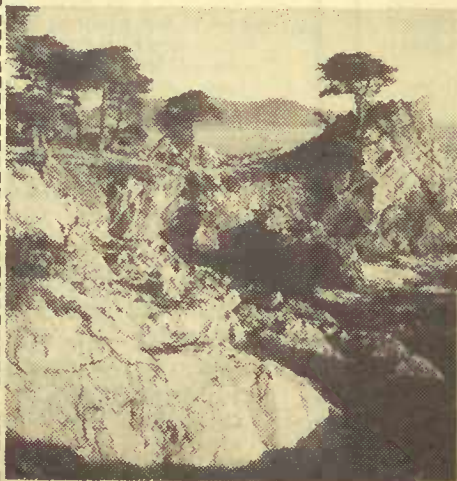
CN-3



## "Tomorrow's" Nursing...

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Phone \_\_\_\_\_  
Graduate of \_\_\_\_\_  
AA \_\_\_\_\_ BS \_\_\_\_\_ Dip \_\_\_\_\_ Yr \_\_\_\_\_  
Area of interest \_\_\_\_\_

CAN 380



## ...is a short drive away from Monterey Bay

Searching for a place where your spare time can be a true source of adventure? This one-time Spanish seaport will capture your spirit with scores of historical sites as well as easy access to the wonders of the Giant Redwoods. It's one of the fascinating places you'll find, a short drive from Stanford University Medical Center.

You will also find "tomorrow's" nursing today in an exciting teaching hospital where non-clinical personnel handle administrative and support tasks so you can concentrate on progressive nursing. You can apply new techniques, participate in research and work with leading authorities in every medical specialty.

We'd like you to know more about our career development programs and our excellent compensation package which includes an innovative time-off program. For additional information, send the coupon to Nurse Recruiter, Personnel Department, Stanford University Hospital, Stanford, CA 94305. Or call collect to (415) 497-7330. For immediate consideration, send your resume and salary requirements. We are an affirmative action, equal opportunity employer, male and female.



Stanford University  
Medical Center



**Foothills Hospital, Calgary,  
Al berta**

**Advanced Neurological-  
Neurosurgical Nursing for  
Graduate Nurses**

A five month clinical and academic program offered by The Department of Nursing Service and The Division of Neurosurgery (Department of Surgery)

**Beginning: March, September**

Limited to 8 participants  
Applications now being accepted

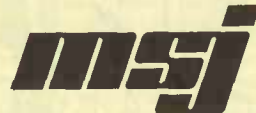
**For further information, please write to:  
Co-ordinator of In-service Education  
Foothills Hospital  
1403 29 St. N.W. Calgary, Alberta  
T2N 2T9**

**Intensive Care Nurses**

300 bed Accredited general hospital in Vancouver requires full-time R.N.s for 4 bed I.C.U. Candidates should be eligible for registration with the RNABC. Previous I.C.U. experience required.

Please apply in writing to:

**Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C. V5T 3N4**



**Royal Jubilee Hospital  
Victoria, B.C.**

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

**Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8**

**Waterford Hospital  
Career Opportunities For  
Registered Nurses**

The Waterford Hospital, a fully accredited 400 bed Psychiatric Institution, affiliated with Memorial University School of Nursing and Medical School, has openings for Registered Nurses in all services, including new, expanded, and acute care services.

An orientation program is offered. Salary is on the scale of \$12,048 - 14,555 per annum. A Psychiatric Service Allowance of \$1,329 per annum is available in addition to basic salary. Both salary and allowance presently under review.

The Hospital is close to all amenities: shopping, transportation and recreation facilities.

Accommodations available in Hospital Residence at nominal cost.

Applications in writing should be addressed to the undersigned:

**Personnel Director  
Waterford Hospital  
Waterford Bridge Road  
St. John's, Newfoundland  
A1E 4J8  
Telephone Number: (709) 368-6061, ext. 341**

**McMaster University  
Educational Program  
For Nurses In  
Primary Care**

McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

**Requirements** Current Canadian Registration. Preceptorship from a medical practitioner. At least one year of work experience, preferably in primary care.

For further information write to:  
**Mona Callin, Director  
Educational Program for Nurses  
in Primary Care  
Faculty of Health Sciences  
McMaster University  
Hamilton, Ontario L8S 4J9**

**Registered Nurses**

Full and part-time vacancies in a new expanding hospital with progressive programmes in long term care, rehabilitation and geriatrics.

Must be eligible for Ontario registration.

Write to:

**Assistant Director of Nursing  
West Park Hospital  
82 Buttonwood Avenue  
Toronto, Ontario  
M6M 2J5**

International Grenfell Association requires  
**Registered Nurses, Public Health  
Nurses and Nurse-Midwives  
(R.N.)**  
for Northern Newfoundland and Labrador.

The International Grenfell Association provides Medical Services in Northern Newfoundland and Labrador. It staffs four hospitals, seventeen nursing stations and many public health units. Our main hospital is a 150 bed accredited hospital situated in scenic St. Anthony, Newfoundland. Active treatment is carried on in Surgery, Psychiatry, Medicine, Pediatrics, OBS/GYN, and Intensive Care.

Orientation and active Inservice Program provided for staff. Salary based on government scales; 37 1/2 hrs. per week. Rotating shifts. Excellent personnel benefits include liberal vacation and sick leave. Accommodation available. Return air fare paid on a completion of a one year service.

Apply to:

**Scott Smith  
Personnel Director  
Curtis Memorial Hospital  
International Grenfell Association  
St. Anthony, Newfoundland A0K 4S0**

**Prince George  
Regional Hospital**

Positions available for experienced nurses or nurses interested in developing their skills in specialty nursing — Operating Room, ICU/CCU, Neonatology Nursing. Must be eligible for B.C. Registration.

- Well developed orientation program
- Inservice Education
- Expanding Operating Room and Obstetrical Suite
- 10 bed ICU/CCU

Prince George Regional Hospital is a 340 bed acute regional referral hospital with a 75 bed extended care unit and has a planned program of expansion.

For further information contact the:

**Personnel Department  
Prince George Regional Hospital  
2000 - 15th Avenue  
Prince George, British Columbia  
V2M 1S2**

**OVERSEAS OPPORTUNITIES**

CUSO has openings in Africa, Papua New Guinea and Latin America for nurses with:

Public Health  
BSc and Master Degrees  
Midwifery

**Qualifications:** All except the midwifery positions require Canadian qualifications.

**Contract:** 2 years.

**Salary:** Low by Canadian standards but sufficient for an adequate lifestyle. Couples will be considered if there are positions for both partners. For more information, write:

**CUSO Health D-1 Program  
151 Slater Street  
Ottawa, Ontario  
K1P 5H5**



University of British Columbia  
Health Sciences Centre  
requires

## Registered Nurses

Opportunities for nurses interested in working as members of the interprofessional team in the new 240 bed Acute Care Unit, of the H.S.C. on the U.B.C. campus.

Positions available in:

- Operating Room Suite
- Intensive/Coronary Care
- Medicine
- Surgery
- Emergency

Nurses must be registered or eligible for registration with the RNABC.

Applicants should apply in writing with detailed resume to:

**Coordinator of Professional Employment**  
Health Sciences Centre  
University of British Columbia  
Vancouver, B.C.  
V6T 1W5

Positions open to both female and male applicants.

OPPORTUNITY

Alberta

## Nurses

Applications are invited for positions at Alberta Hospital, Edmonton, a 650 bed active treatment psychiatric hospital, located 4 km. outside of Edmonton.  
Successful candidates must be graduates from a recognized School of Nursing and eligible for registration in their professional association; willing to work shifts. Vacancies exist in Admissions, Forensic, Rehabilitation, and Geriatric Services.  
**Note:** Transportation is available to and from Edmonton. Accommodation is available in the Staff Residence.

Salary \$1,229 — \$1,445 per month (Starting salary based on experience and education)

Competition #9184-9

This competition will remain open until a suitable candidate has been selected.

Qualified persons are invited to phone, write or submit applications to:

**Personnel Administrator**  
Alberta Hospital, Edmonton  
Box 307, Edmonton, Alberta  
T5J 2J7  
Telephone: (403) 973-2213

## Nursing Unit Coordinator Required By The Thompson General Hospital, Thompson, Manitoba

The Thompson General is a fully accredited 100 bed acute care hospital located in a modern community of 18,000 in North Central Manitoba.

The successful applicant will be given the responsibility of planning, organizing and directing the activities of a 46 bed Medical/Surgical Unit.

Applicants must be eligible for registration with M.A.R.N. Preference will be given to those with Administrative training and/or experience.

The salary range for this position is \$17,600 — \$22,200 per year. Other benefits include Group Life, Pension Plan, free dental program, income protection and remoteness allowance.

Those interested are asked to apply, in confidence, giving details as to experience, education and references to -

**Mr. R.L. Irvine**  
Director of Personnel  
Thompson General Hospital  
Thompson, Manitoba R8N 0C8

Telephone (204) 677-2381

## The University of Alberta

seeks a

## Dean of Nursing

Candidate should have earned doctoral degree, demonstrated scholarship, professional achievement and competence in administration.

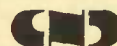
Salary commensurate with qualifications and experience.

Nursing is one of five Health Science Faculties and offers Baccalaureate and Master's level programs.

Starting date: July 1, 1980. Applications and nominations should be received before April 11th, 1980 and should be sent to:

**Dr. R. G. Baldwin**  
Vice-President (Academic)  
The University of Alberta  
Edmonton, Alberta  
T6G 2J9

The University of Alberta is an equal opportunities employer.



## COLLEGE OF NEW CALEDONIA Nursing Instructors

Located in the geographic centre of beautiful British Columbia the College of New Caledonia serves a region of 120,000 people. Applications are invited for positions of full-time Nursing Faculty at the College of New Caledonia for the 1980-81 academic year.

**Qualifications:** Applicants must have a Baccalaureate Degree and must be registered or eligible for registration in British Columbia. Preferably applicants will have two years of nursing practice and teaching experience. In particular Medical-Surgical Nursing experience is preferred.

**Salary:** \$18,050.00 to \$32,450.00 per annum. Placement dependent upon qualifications. Relocation assistance is also available.

Letters of application with the names of three references should be submitted to:

**L. Winthrop**  
Personnel Officer  
College of New Caledonia  
3330 - 22nd Avenue  
Prince George, B.C.  
V2N 1P8

Phone enquiries to the Personnel Officer at  
604/562-2131



## Registered Nurses

Come to work in scenic Corner Brook!

Registered nurses are needed for this 350 bed Regional General Hospital, with detached 60 bed Special Care Unit, serving the West Coast of Newfoundland.

The hospital offers good fringe benefits such as four weeks annual vacation and eight statutory holidays plus birthday holiday. In addition there is a hospital pension plan and a group insurance plan for all permanent employees.

Accommodation and assistance with transportation is available.

Negotiated Salary Scale:

1 January, 1979 — \$12,771.00 — 15,429.00  
1 January, 1980 — \$13,410.00 — 16,199.00  
(Contract not yet signed)

Service Credits recognized.

Interested applicants apply to:

Mrs. Shirley M. Dunphy  
Director of Personnel  
Western Memorial Regional Hospital  
P.O. Box 2005  
Corner Brook, Newfoundland  
A2H 6J7

## Registered Nurses

Planning your summer vacation?

Then by all means, include a visit to beautiful Vancouver in your plans. And while you're here, drop in and discuss your nursing career opportunities at **Shaughnessy Hospital**, an 1100 bed multi-level community teaching hospital.

We have full-time, part-time and float positions available as well as a 2 week orientation for RN's who wish to work on a casual basis only.

When you're in Vancouver please call:

Jane Mann  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C.  
V6H 3N1  
(604) 876-6767

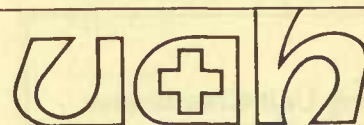
## Registered Nurses

1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including:

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education Programs.  
Post Graduate Clinical Courses in Cardiovascular—  
Intensive Care Nursing and Operating Room Nursing.

Apply to:  
Recruitment Officer — Nursing  
University of Alberta Hospital  
8440 — 112th Street  
Edmonton, Alberta  
T6G 2B7



**University of  
Alberta Hospital**

Edmonton, Alberta



## Are You a Nurse?

### Here's an Opportunity To Be One.

#### Primary Nursing

....at the New Regional Hospital means having direct responsibility for the nursing care of your patient, his family, and working with the doctor as a colleague.

#### Accountability

....as a primary nurse means the outcome of your patient's care is the measure of your effectiveness.

#### Satisfaction

....results from your role as a professional and the significant part you play in the care of your patient.

**PUT IT TOGETHER** with the new 300 bed Fort McMurray Regional Hospital Opening in November, 1979.

Want to know more about your opportunities in our **total patient care** facilities?

Call Penny Albers at (403) 743-3381

or

Write for an information package:

Personnel Department  
Fort McMurray Regional Hospital  
Fort McMurray, Alberta  
T9H 1P2

## Director of Nursing

The Calgary General Hospital invites applications for the position of Director of Nursing Service. The Director will assume responsibility for a large nursing department covering all services in a 960-bed fully accredited active treatment teaching hospital. The nursing department is organized into seven clinical divisions.

This position will appeal to Nursing Managers who have demonstrated their leadership and organizational abilities in progressively senior administrative positions. Advanced preparation at the Master's level and experience in a large teaching hospital would be definite assets.

Applications may be submitted in confidence to:

Mr. E. H. Knight, Executive Director  
Calgary General Hospital  
841 Centre Avenue E.  
Calgary, Alberta  
T2E 0A1

Telephone: (403) 268-9311



**CALGARY GENERAL HOSPITAL**

841 Centre Avenue E.  
Calgary, Alberta T2E 0A1



**Government of  
Newfoundland & Labrador**

## Public Notice

### Cottage Hospital Nurse I's

Applications are invited for appointment on a permanent or short term basis to the Nursing Staff of the Cottage Hospitals at:

**Bonne Bay**

**Harbour Breton**

Salary for Cottage Hospital Nurse 1, annual, sick leave, statutory holidays and other fringe benefits in accordance with Nurses Collective Agreement.

Living-in accommodations available at reasonable rates, also laundry services provided.

Applications should be addressed to:

Director of Nursing  
Cottage Hospitals Division  
Department of Health  
Confederation Building  
St. John's, Newfoundland  
A1C 5T7

Lorne A. Klippert, M.D.  
Deputy Minister

## Director of Nursing

Applications are invited for this senior management position in a fully accredited multi-disciplinary treatment complex of 406 beds, including extensive out patient programmes. Reporting to the Executive Director, fully responsible for organization, planning, administration and operations of nursing care functions.

Candidates must have current registration in Ontario, B.Sc.N. or Masters degree preferable, with demonstrated competent leadership abilities and previous nursing administrative experience at a senior level.

Applicants are requested to submit a comprehensive resume and salary expectations to:

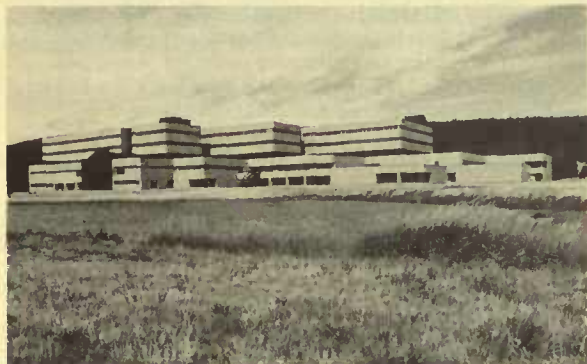
G. E. Pickard  
Executive Director  
Windsor Western Hospital Centre Inc.  
1453 Prince Road  
Windsor, Ontario  
N9C 3Z4



## A Completely Modern Teaching Hospital

### Requires

### Registered Nurses



This 500 bed general hospital is the major teaching facility for the Medical School of Memorial University of Newfoundland.

#### Services offered -

Critical Care, Medical, Surgical Coronary Care, General Surgery, Urology, Gynecology, Medicine, Nephrology, Clinical Teaching, Neurosciences, Cardiology, Cardiovascular Surgery, Orthopedics, Hemodialysis (kidney transplants), Emergency and Out Patient Services, active Rehabilitation Program (adult).

The Staff Development and Training Department offers ongoing lectures and demonstrations in addition to a 6 month diploma course (twice yearly) in — Critical Care Nursing, Neurosciences, Operating Room Nursing.

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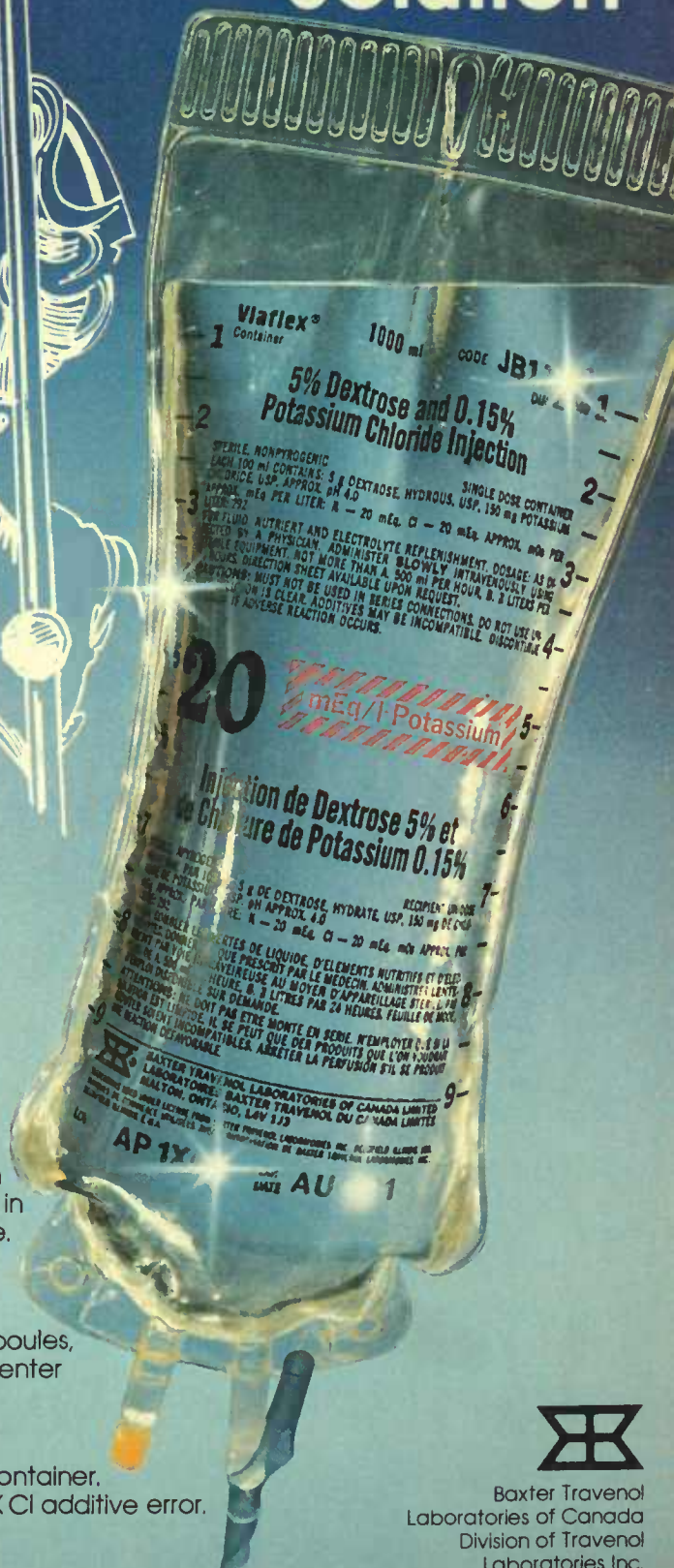
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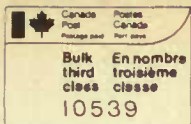
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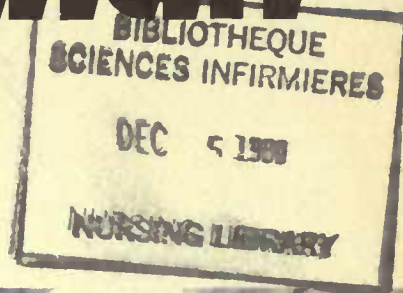


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# The Canadian Nurse



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Fit to travel — Lifestyle is a matter of choice and that's what this issue is all about — whether you're backpacking in Kootenay National Park in Alberta or walking to work. Our cover photo is courtesy of fellow hiker Janet McEwen, RN, of Ottawa.

# The Canadian Nurse

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*The Canadian Nurse* welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

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# perspective

## Guest editorial

In order to promote a particular point of view, I believe that it is necessary to value it, by which I mean to give it high priority, gain knowledge about it, and role model or demonstrate associated behaviors. I question whether the nursing profession truly values fitness and healthy lifestyles to the extent that we give priority to, have knowledge about, and role model healthy lifestyle behaviors.

If we valued healthy lifestyle behaviors, we would take time to promote health behaviors in all clients. Health teaching related to smoking, diet, exercise, stress management and coping skills is seen as a nursing activity. How many of us consistently focus on this area of our practice? How much importance do we place on health teaching? Or is this something that we do only if there is time left over?

Nursing claims to be involved in health promotion, yet the majority of us are illness oriented and indeed have more knowledge about the unhealthy body than the healthy body. Can we be a «health-giving profession» unless we have a knowledge base in health, nutrition, exercise and life skills, and skill in assessment, planning and intervention related to promotion and support of health behaviors?

In relation to role modelling, I must ask whether we ourselves demonstrate healthy lifestyles. By this, I mean a lifestyle that contributes to both mental and physical fitness. Sporadic exercise is not enough. Let's take an honest look. A word of caution though, before you assess your lifestyle. The important thing is to strive to attain a healthier lifestyle, to attempt to maintain balance in your life, *not* to become perfect.

The following are important areas to assess:

- Do you smoke?
- Do you overindulge in drugs or alcohol?
- Do you overeat, eat non-nutritious foods, or undereat?



- Do you have a sedentary style of life?
- Are you overweight?
- Do you deal in an open way with problems and feelings?
- Do you identify and manage stress periods in your life?
- Do you balance activity with rest, work with play, thought with action?

We do not often recognize how non-healthy lifestyle behaviors interfere with our ability to set goals, take risks, make decisions and handle conflicts.

Right now lifestyle and fitness are terms that are regarded positively by the general public. Some of us in the nursing profession have responded by focusing on health promotion as a major nursing function. When the «fad» aspect of lifestyle and fitness has faded will the nursing profession still be there and will it have the credibility to work with others to maintain the high visibility of fitness and health?

This April issue of CNJ marks a special effort to sensitize nurses to fitness and lifestyle. The authors focus on both knowledge and role modelling. We see evidence that some nurses are indeed diagnosing problems and developing interventions related to fitness and lifestyle. But this is not enough. Nursing education programs must develop and build curricula on nursing and health models. We must

convince our employers and the government that fitness and lifestyle do pay off. We must begin research in this area to identify indicators of health and test out interventions related to promotion of health. Some of our closest colleagues in this work will be found in the areas of physical education, kinesiology, nutrition studies and health education.

To promote a greater and lasting focus on health, the total nursing profession must be involved. I hope that this journal will help you look at your own lifestyle but, more than that, I hope that it will motivate you to



take the steps to make health promotion a function of every nurse and a focus of our health care delivery system.

*Irmajean Bajnok is assistant professor, Faculty of Nursing, University of Western Ontario. A member of the Middlesex North Chapter of the Registered Nurses Association of Ontario, she is past president of the RNAO. Irmajean is a graduate of the Winnipeg General Hospital School of Nursing and received her BScN from the University of Alberta and her MScN from the University of Western Ontario.*

*A year ago, in February 1979, she addressed community health nurses attending the National Workshop on Fitness and Lifestyles at Geneva Park, Ontario.*

We care about the shape you're in and so do the members of the Registered Nurse's Association of Ontario and the board of the VON for Canada. They indicated this when they proposed similar resolutions to CNA suggesting a special issue of the journal focusing on fitness and lifestyle.

Initially, CNJ staff approached the project with the goal of presenting a complete look, a handy guide to encourage nurses to look at their own fitness level and lifestyle objectively and as well to incorporate some how to's for change both personally and professionally. It soon became apparent that this was an impossible task and that really all we could do was to attempt to stimulate some dialogue among Canadian nurses.

Now, that this special issue is a reality, we look back on what has turned out to be a very rewarding experience for all of us. The experts whom we contacted for assistance responded with eagerness and, as word of the project spread, enthusiasm grew and we received contributions from nurses all across Canada.

Next month we will continue our look at fitness and lifestyle as we explore what Canadian nurses are doing in their work areas: Judy Proulx of Cochrane, Alberta, has coordinated a «fun and fitness» obesity clinic for children age six through fourteen; Frances Welch tells of her experiences with the Thunder Bay, Ontario Community Fitness campaign, a two-year project in which 22,000 citizens have already participated and Jean Nickerson, along with several of her Nova Scotia colleagues look at the impact of the fitness and lifestyle boom on occupational health nursing in that province.

These and other nurses share their goals and experiences along the rocky road to program implementation. Then to complete our look at lifestyle, we will be reporting on a national nutrition symposium taking place in Toronto in March.



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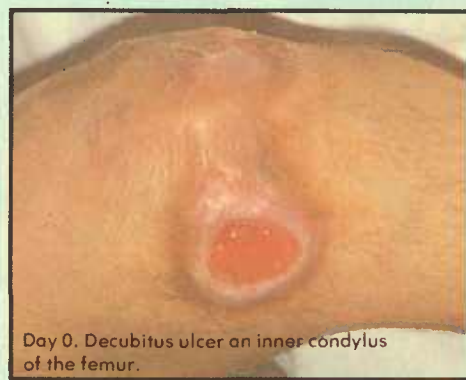


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# Vancouver 1980

## Here it is...

### WHO'S WHO...



**Lorine Besel:** assistant professor, Faculty of Medicine (School of Nursing), McGill University; director of nursing, assistant executive director, Royal Victoria Hospital, Montreal.



**Norma Fulton:** associate professor and director, Continuing Nursing Education, College of Nursing, University of Saskatchewan, Saskatoon.



**Phyllis Barrett:** executive secretary, Newfoundland Association of Registered Nurses.



**Louise S. Lemieux-Charles:** under contract with College of Nurses of Ontario to develop a «Blueprint for the Future of Nursing in Ontario» – part-time counsellor, individuals and couples.



**Aline Michaud:** coordinator advisor, Labor Relations, Fédération des Syndicats Professionnels D'Infirmières et D'Infirmiers du Québec (Fédération des SPIIQ).



**Kathleen M. Clark:** education co-ordinator, Registered Nurses' Association of Ontario.



**Jessica Ryan:** head nurse, Pediatric Service, Chaleur General Hospital, Bathurst, N.B.

### AN INVITATION FROM THE RNABC

*The Registered Nurses Association of British Columbia is looking forward to the CNA biennial meeting in Vancouver this June. As your hosts, we are planning a number of social activities. These will include breakfasts and lunches, as well as evening dinner tours to the Harbour Centre and Gastown, Grouse Mountain and Chinatown. A theatre evening and harbour cruise will also be offered during your stay.*

*In addition to a variety of local tours during non-business hours of the convention, delegates will be offered post-convention tours to Waikiki and Maui, San Francisco, Alaska, Reno and Victoria.*

*Vancouver is a beautiful city with its stunning mountains and sandy beaches. Its art galleries, museums, theatres and clubs are among the finest in the world. The cuisine is varied but specialties are the ethnic foods and seafoods.*

*More information about social activities planned for you, both during the convention and after, can be found in the February issue of the Canadian Nurse. Additional details on activities will be sent to all registrants. We hope you enjoy your stay in Vancouver and that you see as much as you can of our lovely city.*

and...

**Judy Fraser,** occupational health nurse, Winnipeg; **Shelly Kremer,** general duty nurse, Port Moody, B.C.; **Roland Foucher,** Université de Québec; **Ruth Burstahler,** consultant in continuing education, Registered Nurses Association of B.C.; **Rita Lussier,** conseiller en formation professionnelle, OIIQ; **Margaret Steed,** associate professor, director, Continuing Education, Faculty of Nursing, University of Alberta.



# PROGRAM HIGHLIGHTS

Today's issues: tomorrow's nursing

## Sunday, June 22

- 14:00 Canadian Nurses Foundation annual meeting
- 19:30 Opening ceremonies
- Address, «Primary Care—Nursing», Dr. Lea Zwanger, Tel Aviv.  
(Kellogg Foundation Lecture)
- RNABC reception for all registrants

## Monday, June 23

- 09:00 Keynote address: «Who Shapes Nursing in the 80's?»,  
Lorine Besel
- 10:30 Annual meeting
- 12:30 CNA luncheon for all registrants (Guest speaker to be announced)
- 14:30 Feature presentation, Canada's health care system and how it is  
financed, Malcolm G. Taylor, professor of public policy,  
Faculty of Administrative Services, York University (Toronto).
- Reaction panel
- Phyllis Barrett (Nfld.)
  - Judy Fraser (Man.)
  - Shelly Kremer (B.C.)
  - Jessica Ryan (N.B.)
- 17:00 «Meet your candidates» (An opportunity for all registrants to meet  
candidates for 1980-82 term of office.)

## Tuesday, June 24

- 09:00 President's address  
Executive director's report
- 12:30 Election and luncheon
- 14:30 «Labor movement vis-a-vis the professional association»
- Professor Roland Foucher, labor analyst.
  - Aline Michaud, nurse.
  - Louise Lemieux-Charles, nurse.
- 19:30 Dinner and entertainment (RNABC sponsored) for all registrants.

## Wednesday, June 25

- 09:00 General Session
- 11:15 Debate, «Continuing education: mandatory vs. voluntary»
- Ruth Burstahler (B.C.)
  - Kathie Clark (Ont.)
  - Rita Lussier (Quebec)
  - Norma Fulton (Sask.)
  - Margaret Steed (Alta.)
- 12:30 Luncheon
- 14:30 Installation of officers  
President's address

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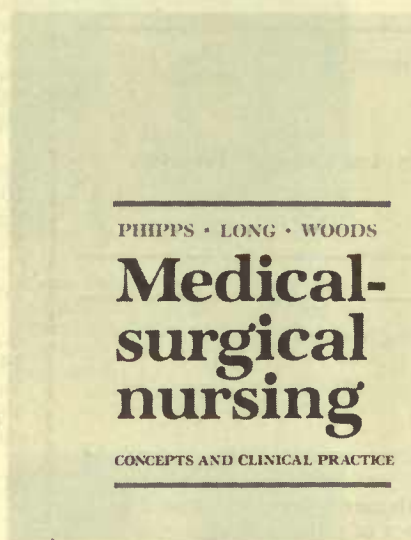
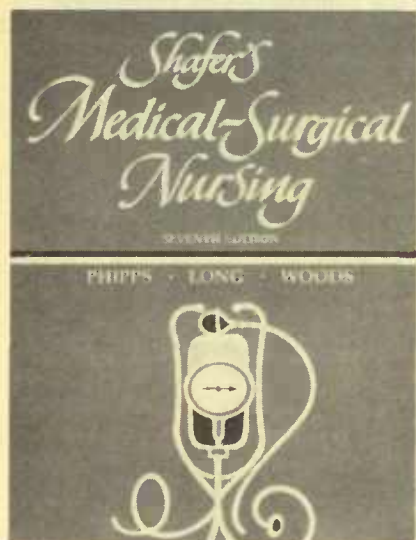
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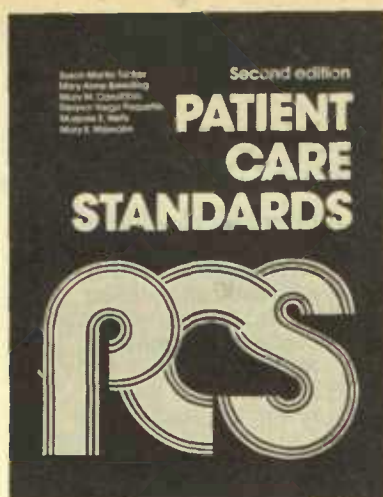
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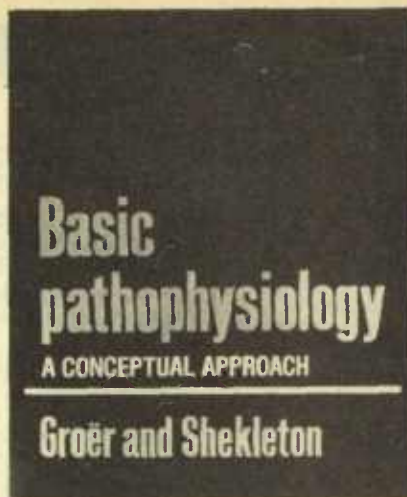




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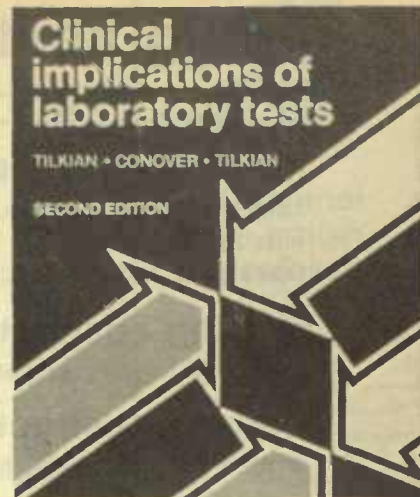
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## news

## CNA's Task Group—a set of Principles for Standards

The definition and standards for nursing practice Task Group has established a set of principles upon which to base the development work underway.

- "We recognize and endorse the use of a conceptual model for nursing practice, education and research in any setting, acknowledging that administration is an integral component in each area."

- **Respecting the freedom of informed choice, we will not impose upon others, our choice of any one of the various nursing models that exist. This freedom of choice will allow for the utilization of a number of nursing models, their eventual testing and further refinement, as well as the construction of new models.**

- We believe that the use of a conceptual model will contribute to improved quality of nursing practice, since it provides direction for the development of behavioral indicators required to evaluate that practice.

- We perceive the nursing process to be the means by which the conceptual model will be applied in nursing practice.

- Since nursing education prepares future practitioners and nursing research contributes to both education and practice, a conceptual nursing model is equally important to each field of activity."

This project is one of the most important CNA Biennium priorities moving into the final phase and aiming at an Annual Meeting/Convention target.

## Research in the '80's Fall Conference Theme

Four professional nursing associations and five university Faculty/Schools of Nursing in the Maritimes will co-sponsor a conference, "Research Basis for Nursing in the Eighties", October 22, 23 and 24 at the Hotel Nova Scotian in Halifax.

A call for papers describing basic or applied research in the practice of nursing has been announced

by project coordinator, Dr. Ruth MacKay. Some papers on research in nursing education and nursing administration where the connection is made to nursing practice may be included. Any nurse researcher practicing in Canada may submit papers which must be accompanied by an abstract of 100-175 words and a current curriculum vitae.

Applications to attend the conference are invited from interested nurses and researchers from other disciplines involved in multidisciplinary research with nurses. Registration is limited to 200 persons. (Fee is \$140 rising to \$160 after September 15. Registrants should make their own hotel accommodation).

The four sponsoring associations are: New Brunswick Association of Registered Nurses, Registered Nurses Association of Nova Scotia, Association of Nurses of Prince Edward Island and Association of Registered Nurses of Newfoundland. The Faculty/Schools of Nursing are Memorial University of Newfoundland, Dalhousie University, St. Francis Xavier University, University of New Brunswick and Université de Moncton.

Information: Coordinator, Research — Nursing in the 80's Conference, School of Nursing, Dalhousie University, Halifax, N.S. B3H 4H7.

**Did you know...**  
The Health Computer Information Bureau in Ottawa is the first attempt in the world to establish a central facility for information on computer use, and users, in the health field. The Bureau wishes to facilitate the exchange of information by publishing a catalogue of user names and a description of the types of computer applications in Canada. To give information or to learn more about the Bureau, contact Marjorie Hayes, RN, BScN, MScN, director, 410 Laurier Avenue West, Suite 800, Ottawa, Ont. K1R 7T6. ♡



# news

## Nurses look at new ways of helping 'young old' and 'old old'.

Gerontological nursing is working on a new image, one that can't help but result in happier patients and happier nurses. The new image is based on a positive attitude towards aging, the belief that mental health can and must be maintained and restored in the elderly.

"Resist the tendency to identify with the helpless, hopeless attitude of many of the elderly," nurses at the third annual meeting of the Gerontological Nursing Association were urged. "One of the most important nursing measures in maintaining mental health in the elderly is continuing to believe that there is something there that is worth maintaining," another guest speaker, Pat Morden, told her audience of close to 200 nurses who work in hospitals, homes for the aged, community agencies and psychiatric institutions throughout Ontario and some agencies outside the province.

Morden urged nurses to get away from the tendency to stereotype elderly patients, to refuse to accept the label of "senile" pinned on an aging patient without reference to an adequate data base.

A nurse clinician at St. Peter's Hospital in Hamilton and consultant in gerontological nursing at the School of Nursing at McMaster University, Morden shared the a.m. session of the program with Dr. Don Wasylenki, consulting psychiatrist in the psychogeriatric program at West Park Hospital in Toronto.

The meeting was the first for the Gerontological Nursing Association since its official incorporation last Fall. Past president Pam Dawson, a clinical nurse specialist with Sunnybrook Medical Centre, introduced the eight members of the new board of directors: chairman Merron McIsaac, Arlene Randall, Fran Morris and Marie Hannum, all of Toronto; Betty McCallum

and Margaret Black of London and Rhona Lampart and Glynnis Gardiner of Hamilton.

The GNA was recognized as an official affiliate of the Registered Nurses Association of Ontario in May, 1979. The latest chapter to join the association is in Hamilton; other cities that have indicated interest in setting up chapters include Ottawa and Winnipeg, as well as a group in Nova Scotia.

Dr. Wasylenki, who described old age as a "season of loss", touched on several significant new findings in his review of normal and pathological changes that accompany aging. Of special significance to nurses is the notion that, contrary to popular belief, there does not appear to be any decrease in the ability of the individual to learn as a person ages. Reaction time, however, may very well increase and nurses should allow for this in assessing the mental function of their patients.

Contemplating the losses of aging, Dr. Wasylenki pointed out that research now indicates that conjugal bereavement rather than retirement is the most significant loss threatening the social organization of the aging individual. "We are also seeing more and more marital conflict among the elderly," he said, observing that often the individual who has trouble adjusting to retirement transfers this conflict to the marital situation.

Nurses should remember that the decision to institutionalize a family member is one of life's most stressful events, resulting often in guilt or depression on the part of the decision-maker — a feeling compounded by the realization that the event is a 'harbinger of one's own fate'. Helping the family to recognize this as a crisis situation and to deal with it appropriately is an important part of the nursing role, Dr. Wasylenki said.

Speaker Pat Morden had several constructive

suggestions to offer nurses in the area of reducing the negative effects of institutionalization, including identification of the caregiver as an individual the patient can call by name, respect for the privacy of a patient, recognition of the continued significance of sexuality in a patient's lifestyle and attention to the appearance of the patient.

Morden identified 'mindlessness' as the chief threat to the mental well-being of the elderly, a condition encouraged by the fallacy that senility is inevitable, by sensory deprivation resulting from loss of sight, hearing and other senses and, often, over-medication. She urged nurses caring for the elderly to provide their patients with the time and the information they need to make their own decisions, to assume as much responsibility for their own care as possible and to give them meaningful tasks.

The conference committee was headed by Christine Souter, staffing supervisor, Riverdale Hospital in Toronto. Also participating in the program were Mary Kay Harrison, clinical specialist, psychiatric nursing, coordinator of the psychogeriatric program at West Park Hospital and Marguerite Williams, coordinator of special projects and consultant in gerontological nursing, Rosedale Pain Treatment Centre, Toronto.

More information on the GNA may be obtained by writing to:

Gerontological Nursing Association  
PO Box 368, Station "K"  
Toronto, Ontario, M4P 2G7.

### Did you know...

The Ontario Deafness Research Foundation, newly formed to assist research in the cause and treatment of deafness, will be awarding grants annually for research in these fields. This year's grants totalled \$68,000.00.

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Contributors: Thomas Bond, M.T. (ASCP), B.S., M.S.; Carita Y. Klindtworth, R.N., B.S.N., M.S.; Marilyn J. McDonald, R.N., B.S.N., M.A.; Anthony R. Scalisi, R. Ph., B.S. in Pharmacy.

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# calendar

## Provincial Annual Meetings

The Registered Nurses Association of Ontario will hold its annual meeting May 1-3 at the Royal York Hotel, Toronto. Contact: *RNAO, 33 Price Street, Toronto, Ont. M4W 1Z2.*

The Saskatchewan Registered Nurses Association will hold its annual meeting May 6-8 at the Sheraton Cavalier Motor Inn, Saskatoon, Sask. Contact: *SRNA, 2066 Retallack St., Regina, Sask. S4T 2K2.*

The Alberta Association of Registered Nurses will hold its annual convention May 6-9 at the Capri Centre, Red Deer. Contact: *Brenda Laing, Information Officer, AARN, 10256, 112th St., Edmonton, Alberta T5K 1M6.*

The Registered Nurses Association of British Columbia annual meeting will be held May 7-9 in Vancouver. Contact: *RNABC, 2130 W. 12th Ave., Vancouver B.C., V6K 2N3.*

The Association of Nurses of Prince Edward Island will hold its annual meeting May 7 at Summerside. Contact: *ANPEI, 41 Palmer's Lane, Charlottetown, Prince Edward Island C1A 5V7.*

The Manitoba Association of Registered Nurses will hold its annual meeting at the Winnipeg Convention Center, May 22 & 23, with a theme of Spotlight on Nursing—The Year 2000. Contact: *MARN, 647 Broadway Ave., Winnipeg, Manitoba R3C 0X2.*

The New Brunswick Association of Registered Nurses will hold its annual meeting at Keddy's Motor Inn, Fredericton June 3-5. Contact: *NBARN, 231 Saunders St., Fredericton, New Brunswick, E3B 1N6.*

"Expectations of the Nurse in the Eighties is the theme of the 71st annual meeting of the Registered Nurses Association of Nova Scotia, which will be held June 11-13 at Acadia University, Wolfville, N.S. Contact: *RNANS, 6035 Coburg Rd., Halifax, Nova Scotia, B3H 1Y8.*

## April

**Therapeutic Touch: An Ancient Nursing Intervention**, given in two parts, with separate registrations for both days, April 17 and 18. Contact: *Mrs. Dorothy Miles, Director, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario.*

**Pediatric Emergency Conference** presented by The Hospital for Sick Children, Toronto, will be held April 24 and 25, 1980. Contact: *Betty Cragg, Coordinator, Nursing Education, The Hospital for Sick Children, 555 University Avenue, Toronto, Ont. M5G 1X8.*

"Mental Health or Mental Illness?" is the theme of the Greater Vancouver Mental Health Service Conference, April 22 & 23. Contact: *G.V.M.H.S. Conference Committee, 201-828 West 8th Ave., Vancouver, B.C., V5Z 1E2.*

The British Columbia Operating Room Nurses Group will present their seventh biennial Institute April 24-26 at the Hotel Vancouver. Contact: *Registration Chairman, Mrs. Sheila Giles, 8-1385 W. 11th Ave., Vancouver, B.C.*

The Operating Room Nurses of Greater Toronto are presenting the sixth National Conference to be held Apr. 28-May 1, 1980 at the Skyline Hotel, Toronto, Ontario. Contact: *Virginia Gardhouse, Convener, Publicity Committee, 580 The East Mall, Apt. 404, Islington, Ont.*

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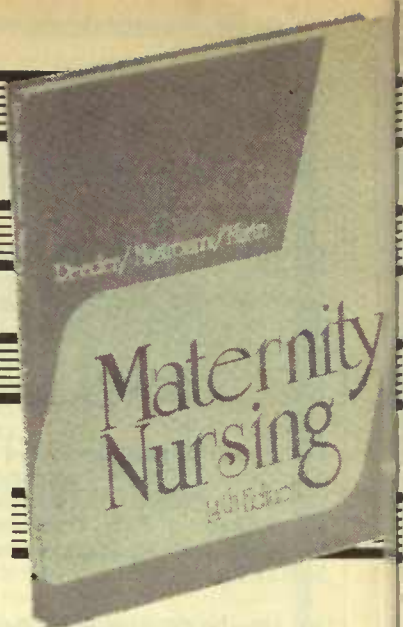
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By LuVerne Wolff Lewis, R.N.,  
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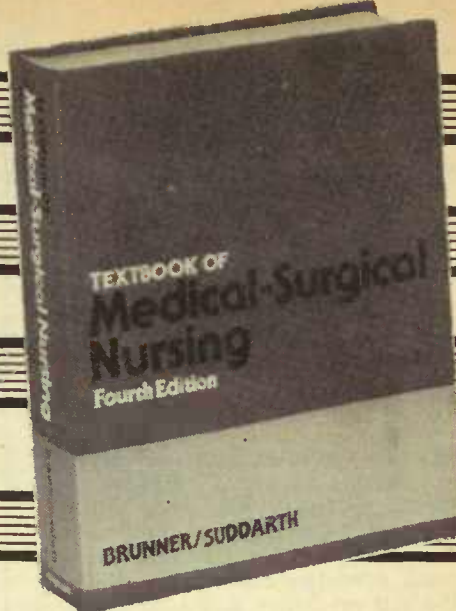
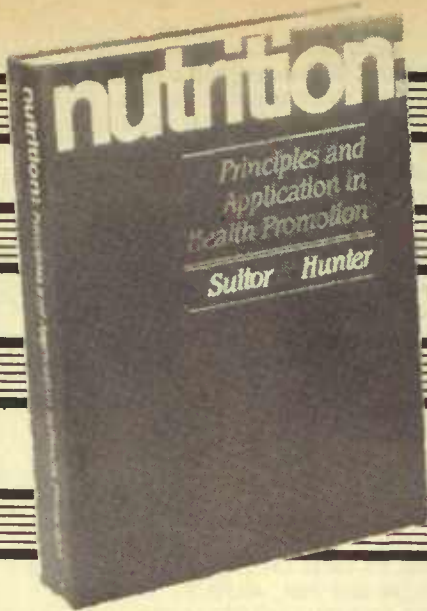
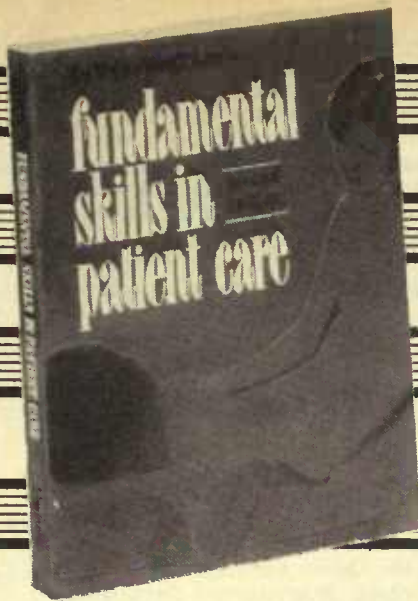
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Department of Nursing. *The Hospital for Sick Children, Toronto.* Edited by U. F. Matthews.

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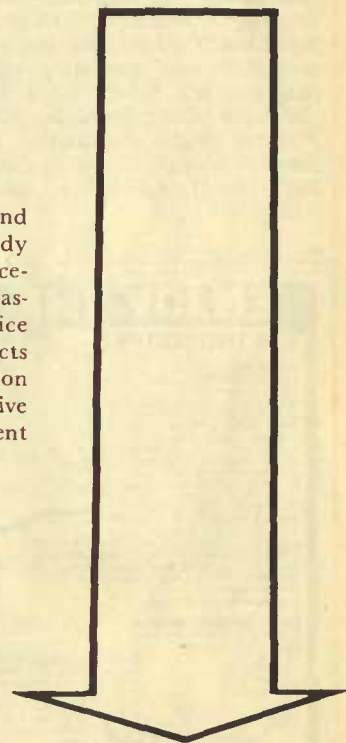
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## **CANADIAN NURSES ASSOCIATION**

### **TICKET OF NOMINATIONS**

**1980-82 Mandate**

**President Elect**  
(1 to be elected)

**Helen Preston Glass**

**Vice-Presidents**  
(2 to be elected)

**Simone-Marie Cormier**  
**Myrtle E. Crawford**  
**E. Sue Rothwell**

**Member-at-Large**  
**Nursing Administration**  
(1 to be elected)

**Mary E. Murphy**  
**Ginette Rodger**

**Member-at-Large**  
**Nursing Education**  
(1 to be elected)

**Margaret A. Campbell**  
**Sister Marie Simone Roach**  
**Patricia S. B. Stanojevic**  
**Margaret Steed**

**Member-at-Large**  
**Nursing Research**  
(1 to be elected)

**Peggy Anne Field**  
**Fabienne Fortin**  
**Odile Larose**  
**Marian McGee**

**Member-at-Large**  
**Social and Economic Welfare**  
(1 to be elected)

**Mary Lou Annable**  
**Phyllis Goertz**

**Member-at-Large**  
**Nursing Practice**  
(1 to be elected)

**Committee on Nominations**  
(3 to be elected)



## President



**Shirley M. Stinson, BScN (U of Alberta), MNA (U of Minnesota), EdD (Columbia U)**

### **Present Position:**

professor, Faculty of Nursing and Division of Health Services Administration, U of Alberta, Edmonton.

### **Association Activities:**

AARN—member of committee on nursing research (1973-77); member of ad hoc committee on the Chichak Report (1971-72). CNA—president-elect (1978-80); 1st vice-president (1976-78); member-at-large for Nursing Education (1974-76); chairman (1971-73) and member (1972-76) of special committee on nursing research.

### **Professional Affiliations:**

Economic Council of Canada, member, health services committee (1973-74); Kellogg National Seminar on Doctoral Preparation for Canadian Nurses (1978), project director. Author of numerous articles and reports.

**The question is not, "Do we need a national professional nursing organization?"** for in this day and age every occupation that would deem itself a profession needs some sort of collective national voice, but, "For what ought we, and ought we not, use CNA?" It is toward providing leadership for answering that question in terms of concrete relevant actions that I am prepared to commit myself as president.

## Candidate: President elect



**Helen Preston Glass, BS, MA, M.Ed., EdD (Columbia U)**

### **Present Position:**

co-ordinator, Graduate Program in Nursing, School of Nursing, University of Manitoba, Winnipeg.

### **Association Activities:**

MARN—president, board of directors (1966-68); chairman, Committee of accreditation (1963-68); chairman, Committee on Education (1963-68); chairman, Committee on the Development of Nursing Education in Manitoba (1963-68); chairman, Ad Hoc Committee on Nursing Research (1971-76); chairman, Committee to prepare a Position Paper on Nursing Education (1974-76); member, Blueprint Committee, Transition of Diploma Schools of Nursing into the Educational Sector (1976); member, Board of Examiners (1966); member, Directors of Schools of Nursing Interest Group (1975); member, Committee to study the Report of the Joint Ministerial Task Force in Nursing Education (1978); member, National Health Research Programs Development Review Committee 48 (1975-79); chairman, Committee on Careers (1963-68). CNA—board of directors, (1966-68, 1976-78); Sub-Committee on Nursing Education (1964-66); Special Committee on Nursing Research (1970-76); chairman, Special Committee on Nursing Research (1976-78); Committee to Develop Standards for Nursing Education in Canada (1975- ); Committee on Doctoral Preparation for Nurses in Canada (1977- ).

### **Professional Affiliations:**

Canadian Nurses Foundation; Canadian Association of University Schools of Nursing;

National Nursing Committee, The Canadian Red Cross Society; National League for Nursing; Council of Baccalaureate and Higher Education; Task Force on Euthanasia and Definition of Death, Law Reform Commission of Canada. Author of numerous papers and reports.

**The profession of nursing** has developed into a viable effective force in Canada, in response to unmet health needs. I believe nurses are in the best position in the health field to develop new avenues of care and to initiate changes rather than react to them. Nurses will be called upon increasingly, to practice nursing on an intellectual level and to demonstrate excellence in practice. As we move into an era of substantial independence there is need for research to determine the effectiveness of various forms of nursing intervention and their impact on practice. Further, there is need to unravel ethical dilemmas in the increasing moral and scientific complexity of our society. We will be required to assure Canadians of the quality of our nursing care and our willingness to work with governments and other professional and allied groups to attain that quality.

In endorsing these beliefs it would be my desire, if elected, to further educational developments in nursing, particularly the Canadian Nurses Association's efforts towards ensuring doctoral preparation for nurses. I was involved in the Kellogg Proposal in this regard, and also instrumental in the initiation of the first National Conference on Nursing Education held this past year. I would endorse further forums extending these to nursing practice and to nursing administration so that ideas and concerns in these areas can be explored by nurses. I support continuing conferences on nursing research and the expansion of research to involve more of the nursing population.

The development of standards of nursing practice is launched but needs to be followed by close liaison with social security measures for nurses to augment quality assurance in the provision of nursing care. There is much to be done. My qualifications and experience would enable me to put my efforts in these directions if elected.



# Candidates: Vice-president



**Simone-Marie Cormier, Diploma in Nursing (L'Ecole d'Infirmières St. Joseph and L'institut "Deux Alice", Brussels, Belgium)**

## **Present Position:**

director of nursing, Hôtel Dieu Hospital, Campbellton, N.B.

## **Association Activities:**

NBARN—president (1975-77); 1st vice-president (1974-75); 2nd vice-president (1973-74); Nursing Committee (1973- ). CNA—Board of Directors (1975-77).

**I have accepted** the nomination as vice-president of the Canadian Nurses Association because, as a nurse, I am interested in nursing and in health care.

To me, as long as a nurse is actively involved in nursing, she must be an active member of her association.

I believe that nurses are unique in their contribution to health care and therefore, I want to become involved in the activities and in the decisions that involve nurses and the profession.

Our future belongs to us and I would welcome the opportunity, if elected, to serve for nurses and nursing.



**Myrtle E. Crawford, BSN (U of Saskatchewan), MA (Columbia U)**

## **Present Position:**

assistant dean, College of Nursing, University of Saskatchewan, Saskatoon.

## **Association Activities:**

CNA—Board of Directors (1963-65); member of various committees, including, Standing Committee on Nursing Education, and Special Committee to Review the Task Force Reports on Health Services in Canada; presently 2nd vice-president, member of board, chairman, Ad Hoc Committee on Accreditation.

## **Professional Affiliations:**

Canadian Association of University Schools of Nursing; National League for Nursing; Medico-Legal Society of Saskatoon.

**It has been said** that nursing is at a crucial stage in the development of the profession. Decisions that are made now are expected to have implications for health care into the 21st century. There is an appreciation of the increasing need for assertiveness so that we may provide the best services for our clients. The national nursing association must be ready to supply both support and leadership in approaching the health care issues that arise.

CNA has recently sponsored a National Forum on Nursing Education. Papers were given and discussions were held that underlined the necessity for nursing practitioners,

administrators and educators to plan together so that the nurse of today will be well prepared to deal with the problems of tomorrow. The need to research in nursing was also apparent. This is a very challenging time for nursing and CNA should be prepared to meet the challenges.

A heavy responsibility is placed on the members of the Board of Directors to make decisions on behalf of the larger membership of CNA. I feel that my current term on the Board of Directors has given me a good basis for decision-making in the coming biennium.



**E. Sue Rothwell, BS (Cornell U), MS (U of California)**

## **Present Position:**

director of nursing and assistant professor, Cancer Control Agency of British Columbia, Vancouver.

## **Association Activities:**

RNABC—president, (1977-79); numerous committees. CNA—board of directors (1977-79).

## **Professional Affiliations:**

American Association for the Advancement of Science (AAAS); Oncology Nurses Society.

**I have accepted** the nomination for the office of vice-president of the Canadian Nurses Association because I think that the experience I gained as president of the Registered Nurses Association of British Columbia and concomitantly as a director on the board of the Canadian Nurses Association has prepared me to serve Canadian nurses well as a member of the executive of their national association. The nursing profession in Canada needs a strong national association. And, if you elect me, I will see as my overriding objective the strengthening of our national role.

Today in Canada, changes in politics, economics, health care and the attitudes toward professions force us to critically examine our national presence. We need better communication and cooperation among provincial nursing associations to address national issues in health care. Economic constraints will mean more cutbacks in health care and research dollars. Nurses need to shape tomorrow's health care and to do this we will have to work closely with other health professionals at national policy making levels.

Among ourselves, we are questioning the relationship of professionalism to the labor relation function. The public has asked repeatedly if professions are, in fact, self-interest groups. We need to talk openly among ourselves and with the public about our own perspective and what is expected of us.

These are some of the issues which I would be prepared to deal with as a member of the Canadian Nurses Association executive. I think our national association has built a strong education and research base within the profession of nursing. If the Canadian Nurses Association is to realize its potential as a national association, we must begin now to build a strong nursing presence for the public, government and other professions.



# Candidates: Member-at-large, Nursing Administration



**Mary E. Murphy, BScN (U of Windsor), MHA (U of Ottawa)**

**Present Position:**

vice-president, Nursing,  
Vancouver General Hospital,  
Vancouver.

**Association Activities:**

AARN—member, Ad Hoc  
Committee on Continuing  
Education, chairman, Ad Hoc  
Committee on Graduate  
Education.  
RNAO.

**Professional Affiliations:**

Association of Nursing  
Administrators of General  
Hospitals in Edmonton; Western  
Council of Teaching Hospitals;  
Council of the Faculty of Nursing,  
University of Alberta; College of  
Nurses of Ontario.

**Without diminishing the caring,**  
concern and commitment which  
are at the core of professional  
nursing, one must constantly  
strive to bring the most relevant  
and current information available  
to the task at hand.

The development of nursing  
is best served by diversity of  
educational preparation, the  
implementation of precise  
research findings, the acquisition  
and support of highly prepared  
and skilled practitioners and  
knowledgeable administrators.

The 60's addressed the  
quality of our caring. The 70's  
advocated dialogue and  
collaboration; hopefully the 80's  
will see the implementation of  
these plans and aspirations.



**Ginette Rodger, BN (U of Ottawa), M. Nurs. (Admin.) (Université de Montréal)**

**Present Position:**

director of nursing, Notre Dame  
Hospital, Montreal.

**Association Activities:**

OIIQ.  
CNA—member-at-large, Nursing  
Administration (1978-80).

**Professional Affiliations:**

Comité d'étude sur la Formation  
en Sciences Infirmières, Ministère  
de l'éducation, president;  
Canadian Council on Hospital  
Accreditation; Conseil sur le  
maintien des Services de Santé et  
des Services Sociaux;  
CNA-CHA-CMA-CPHA  
Quadrupartite Committee;  
Association des hôpitaux de la  
province de Québec; Federation  
of Administrators of Quebec  
Health and Social Services;  
American Society for Hospital  
Nursing Service Administration.

I have accepted the nomination  
as member-at-large for Nursing  
Administration because I believe  
that, as director of nursing in a  
very active 1,000 bed university  
hospital, I can make a valuable  
contribution to the Board of  
Directors. During my five years as  
a director of nursing, I have gained  
varied and valuable experience.

Facing up to the realities of  
the administrative field of the 70's  
and 80's has been part of my  
everyday responsibilities.  
Adapting to rapid change in a  
world of unrest, professionalism,  
politically-oriented unionism,  
research and teaching, while  
ensuring quality and quantity of  
care in spite of limited resources is  
the nursing administrator's daily  
challenge.

Furthermore, being a  
member of the Board of Directors  
at the national level is a rewarding  
professional experience which  
can only prove to be positive as far  
as acquiring and sharing  
knowledge is concerned and can  
only lead to my better serving my  
profession.

If you think I can adequately  
represent nursing administration  
on the Board of Directors, I can  
assure you of my continued  
interest and availability.

# Candidates: Member-at-large, Nursing Education



**Margaret A. Campbell, BA, BASc(N) (U of British Columbia), MS in Nursing (Western Reserve University), EdD (Columbia U)**

**Present Position:**

professor, School of Nursing,  
University of British Columbia,  
Vancouver.

**Association Activities:**

RNABC—member, executive and  
board (1958-64, 1965-67);  
chairman, Committee on  
Legislation, Constitution and  
Bylaws (1958-60, 1965-67);  
chairman, Committee on Nursing  
Education, (1960-64); chairman,  
Bursary Loan Committee  
(1960-64); member, Board of  
Examiners (1971-74); member,  
Committee on Bursaries, Loans  
and Scholarships (1972-75);  
chairman, Committee on Approval  
of Schools of Nursing (1972-76);  
chairman, Task Committee to  
Identify the Critical Components of  
a Basic Nursing Program  
(1974-76); member, Steering  
Committee on Roles and  
Functions (1977- ); chairman,  
Task Committee to study the  
Kermacks Report on Nursing  
Education (1979); chairman, Task  
Committee to Review and Revise  
Policies, Procedures and Criteria  
for Approval of Schools of Nursing  
(1974-76).



CNA—member, Committee on Nursing Education (1960-64); member, Committee and Subcommittee on Legislation and Bylaws (1964-66); member, CNA Testing Service Master Blueprint Committee (1970-73); member, CNA Testing Service Ad Hoc Committee on Comprehensive Examinations (1973); member, Ad Hoc Committee on Accreditation (1979).

#### **Professional Affiliations:**

Canadian Nurses Foundation, member, selections committee, 1974; Canadian Association of University Schools of Nursing — Western Region.

**As a federation** of provincial and territorial associations, the Canadian Nurses Association represents nursing both nationally and internationally. As nursing's representative, the CNA speaks for those who, in Canada, comprise the largest group of professional workers in the health care field. I believe that the association has not only the prerogative but also the responsibility to be instrumental in helping to shape the health care services in Canada — to be proactive, not just reactive to what is occurring in health care today.

Internationally, the Canadian Nurses Association must continue to support other national nursing associations as they strive to effect changes in health care delivery in their countries.

To meet its commitment to quality health care in Canada requires a Board of Directors which has the vision to identify nursing's role in the changing health care scene and the wisdom to establish policies and to take positions which will clarify and promote the role. Structurally, the board has the potential to fulfil this requirement: all facets of professional nursing — administration, education, practice, research and social and economic welfare — are represented. I believe that those nurses who represent these facts are responsible for being sensitive to the health care scene and the forces impinging on it, for recognizing the implications for nursing, and for responding appropriately.

In particular, the member-at-large for nursing education must be alert to those issues which have or could have significance for the preparation of nurses in all types of educational programs. I believe that my experiences in teaching and in professional association committees would help me to contribute to the challenging work of the CNA Board of Directors.



**Sister Marle Simone Roach, BScN (St. Francis Xavier U); MS Admin. Nursing Education (Boston U), PhD Foundations of Education (Catholic University of America).**

#### **Present Position:**

On two-year study leave from St. Francis Xavier University, Antigonish.

#### **Association Activities:**

CNA—currently director, Code of Ethics project.  
RNANS—chairman, Nursing Service (1956-58).

#### **Professional Affiliations:**

Canadian Association of University Schools of Nursing, secretary, 1972-74.

**This is an exciting time**, first of all, to be a Canadian. It is also a challenging time to be a nurse, given the dynamically changing nature of society, and the impact of societal changes on the profession of nursing.

To be involved with the Canadian Nurses Association through its Board of Directors, would provide a singular opportunity to be part of the process that will shape nursing in this country. It would, most importantly, provide an opportunity to fulfill a personal responsibility to contribute to this process by sharing my own insights and skills.

During most of my professional career, I have been interested in the philosophical basis of nursing. In the wake of increasing ethical issues in nursing, I am concerned about the basis for, and the process of, ethical decision-making. I believe that I can make some small, but important contribution to the discernment of some of the issues that face the profession, and to the deliberations about what we want nursing to be in Canada.



**Patricia S.B. Stanojevic, BScN, (U of British Columbia), M.Sc (App), (McGill U)**

#### **Present Position:**

staff development officer, George Brown College, Toronto.

#### **Association Activities:**

RNAO—vice-president, Alexandra Chapter (1977-78); member-at-large, Education (1978-80); chairman, Working Party on approaches to facilitate the fit of the new two-year graduates - 1978; past chairman, Toronto area Nursing Education Administrators Group (1975-77).

#### **Professional Affiliations:**

College of Nurses of Ontario, member, Finance Committee.

**Nursing must face** the challenges of the 80's as a united force in society. For this reason, I have accepted the nomination for the office of member-at-large, Nursing Education, because I believe my background has prepared me to appreciate the issues facing nursing throughout Canada.

Nursing's unity comes from its common goal of assisting the client to achieve his/her optimum state of health. Nursing service contributes to that goal by providing direct services to the client. And nursing education is responsible for providing educational opportunities to achieve that goal.

I would promote the fostering of collegueship, collaboration and cooperation among all practitioners of nursing. Nursing administration, service and education must agree on realistic goals for nursing education programs. In particular, we must work closely to assist the student to move into the new role of worker.

Another challenge we face as nursing educators is to provide a wide variety of vehicles by which all nurses, regardless of where they live, may maintain their competence throughout their lifetime in nursing. We must assist nurses to keep pace in a rapidly changing world.





**Margaret Steed, BN Admin,  
(McGill U), MA (Columbia U)**

**Present Position:**

associate professor, director, Continuing Education, Faculty of Nursing, University of Alberta, Edmonton.

**Association Activities:**

AARN—chairman, Nursing Research (1974-77); Nursing Education Planning Committee, (1969-75); Nursing Practice Planning Committee (1969-75); Council (1978-80); Executive of North Central District (1978-80); Standing Committee, Legislation (1979- ); Ad Hoc Committee, Continuing Education (1978- ); "Dialogue" planning for nursing education service, coordinated seminars, (1979).

**Professional Affiliations:**

University Coordinating Council, board of examiners of nursing (1964-74); Canadian Nurse Registration Examinations, master blueprint committee, (1971-73); Directors of Inservice Edmonton Hospitals; Directors of Continuing Nursing Education in Alberta; Canadian Association of University Schools of Nursing; author of many documents, studies and articles.

**I am pleased to accept the nomination for the office of member-at-large representing nursing education for the Canadian Nurses Association.**

I accept this nomination having taught in every major type of educational program offered for nurses, from two-year diploma to graduate school. In addition I have been involved in a wide spectrum of activities related to nursing education including consultation services — (planning and implementation aspects, curriculum, teaching and evaluation); assisting with or preparing briefs, position papers and commission reports and

conducting workshops. These activities have been carried out at international, national and provincial levels.

I believe the total of my personal and professional experiences helps me to relate to the many facets of nursing education and makes it possible for me to conceptualize professional nursing with its interrelated ramifications for education and practice.

Selected personal high priorities include:

- a continued search for means to ensure competency of nurses in face of rapidly changing technology and the expansions of medical and scientific knowledge.
- a cognizance of the need for nursing education to be responsive to the changing health and illness needs of society while still providing sound basic education.
- the need for the organized profession of nursing to maintain a stronger role in determining the destiny of the profession.
- the establishment of a national accreditation program for nursing education programs.
- continued efforts to enlarge and strengthen continuing education offerings for registered nurses.
- concentrated efforts to provide doctoral preparation for nursing in Canada.
- increased support and activities for the inclusion of administrative skills in nurse preparatory programs at various levels.
- increased support and activities for advanced study in clinical nursing practice in graduate nurse education.
- the promotion of collegial relationships between education and service institutions.
- the promotion of collaborative relationships and the sharing of ideas for the development of graduate nurse education, between the various universities in Canada.

I see nursing education in Canada at the threshold of great steps forward with the introduction and strengthening of both basic and graduate education, a clearer delineation of professionalism and a sounder research base. I would like to be involved in the dynamics of the continued evolvement.

# Candidates: Member-at-large Nursing Research



**Peggy Anne Field, BN (McGill U), MN (U of Washington),  
Doctoral Candidate in  
Education (U of Alberta)**

**Present Position:**

associate professor (on leave), University of Alberta, Edmonton.

**Association Activities:**

AARN—Nursing Committee (1975-78); chairman, Ad Hoc Committee to Study Post RN Education (1977-78); Advanced Education Liaison Committee (1977-78).

**Professional Affiliations:**

Western Nurse-Midwives Association, president, (1978- ); Canadian Association of University Schools of Nursing, member, Committee on Accreditation, Royal College of Midwives; National Association of College of Obstetricians and Gynecologists.

**It is my belief** that Canadian nursing research should encourage a wide range of approaches to investigation. Both qualitative and quantitative methodologies have their place in answering questions posed in response to identified nursing problems. While clinical nursing research should be given priority, research based on philosophical and historical issues must not be ignored.

The current concerns of CNA with nursing practice standards and with accreditation of schools of nursing demonstrate the need for research input. This is necessary for the association to take a firm and well documented stand on nursing issues. This requires prepared nurse researchers capable of generating a body of knowledge.

Research in the practice of nursing must involve both researchers and practitioners in the identification of problems for study and in the collection of data. More encouragement must also be given to practitioners to read and to examine studies for their significance for practice. There is a need to provide education for practitioners so that they are able to become intelligent consumers of nursing research.

Support must be given to programs which educate nurse researchers. This preparation must be at both masters and doctoral level. The national association must continue to work toward the establishment of a doctoral program in nursing so that nursing research capabilities will be expanded.

Another area of concern must be the identification of funding sources for research. Funding bodies must be persuaded of both the viability and the urgency of nursing research.

Research must be seen by all CNA members as a responsibility of nursing if it is to be viable. We as nurses must identify problems; we must collect data; we must read research reports; and we must implement findings.

As CNA member-at-large I would encourage a national policy that looked at the needs of the practicing nurse, the researcher, the educational programs and the resources for nursing research.





**Fabienne Fortin, BScN**  
(Université de Montréal), M.Ed.  
(U of Ottawa), M.Sc. (McMaster  
U), PhD (McGill U).

**Present Position:**

assistant professor, Faculté des sciences infirmières, Université de Montréal.

**Association Activities:**

OIIQ  
RNAO.

Like other professions seeking to enhance their professional image, nursing undertakes the continual development of a body of scientific knowledge fundamental to its practice. As a body of knowledge, nursing still has many of the signs of an immature discipline. Whether or not it grows to maturity in the next decade or two will depend very much on the wisdom with which we choose the focus of our research. An immature discipline is characterized by J.R. Ravetz as one lacking in a body of stable factual knowledge. For many years nurses cared for patients where practices were largely intuitive and prescientific.

Although, at present, nursing does not possess a body of structural scientific knowledge, R.M. Schlotfeldt wrote that nurses are convinced that they need a scientific base with which to guide their practice. It is only when the practitioner has a body of scientific nursing knowledge upon which to rely that she will feel confident that the way in which she cares for patients is designed to bring about the best results in the recipients of care.

One essential activity of the scientific method rests on theory building. It is theory which organizes and gives meaning to data, helps to formulate problems, and provides the basis for the interpretation of empirical findings. As a science matures, its body of factual information becomes embedded in an explanatory theory of increasing power and significance. Our research must be based on sound principles and a clear understanding of the nature of nursing as a body of scientific knowledge.

An immature discipline can make a useful contribution to knowledge if it concentrates on three areas of nursing: research, practice and education. The question of how research in nursing practice relates to patient care and teaching is of great interest. Attention should be directed to the role of the nurse in research and how cooperative and collaborative relationships can be established to facilitate research in both university and community settings. To conclude with Ravetz: "Immature fields with the hope of imminent maturation are, with all their attendant hazards, the place where the greatest challenge is to be found."



**Odile Larose, BN, M. Nurs.**  
(Admin.), (Université de  
Montréal)

**Present Position:**

director of Nursing Sector, Ordre des Infirmières et Infirmiers du Québec.

**Association Activities:**

OIIQ—credential committee (1976-77); committee on permits (1978).  
CNA—member-at-large, Nursing Research (1978-80); Special Committee on Nursing Research (1974-78).

**Professional Affiliations:**

Association des hôpitaux de la province de Québec, committee on shortage of nursing staff; author of numerous articles in nursing and hospital administration publications, as well as OIIQ documents.

After four years as member of CNA's special committee on nursing research and the last two years as member-at-large, nursing research, I can only say that my deepest convictions concerning the necessity of developing nursing research at the national level have been verified, confirmed and sustained.

If my nomination was confirmed in 1978 it is because there was confidence that I would emphasize research and thus orient nursing to a style adapted to the needs of a population living in an ever changing social context.

I will only mention in passing that the marked interest I have in research stems from both the individual's and the community's needs in the health field, needs which can best be served by nurses who because of the very nature of their profession, are in the best position to intervene while taking into account all the individual's bio-psycho-social dimensions in relation with the health-sickness continuum.

Being close to the community, finding out its health needs and adequate nursing answers presupposes continued action and firm positions by the national association at the level of the working environment of the nurse as well as within the various organizations. It would certainly be deplorable to witness apatragmatism in our profession due to ignorance of the value of research and lack of interest in giving it the importance it needs in order to serve as an historical beacon for our profession.

As I said in 1978, nursing research is a prime component and must serve as a base for our profession by making it live not only at the university level but also in the whole health field and in nursing associations.

If a step was taken since 1978 through noticing the importance of setting up a position of director of research projects for the CNA and by establishing certain essential mechanisms promoting nursing research, many other things remain to be done. I would like therefore to continue what I have already undertaken by promoting research in Canada and participating in the elaboration of prospectives for nursing, among other things, through my support for the setting up of a doctoral program in nursing in Canada.

Also, since 1978, I can frankly say that I have been available and very much involved in consultation concerning research programs for different organizations as well as actively engaged in developing the different components of the nursing profession. I have also participated in different decisions concerning the future and the direction to be given to the roles and functions of nursing in society as a whole.

If the future of our profession is in the hands of nurses, our representatives at the national level are there to guarantee our motivation in promoting our nursing way of life. Therefore, I sincerely hope I will be able to work once again with all the other members of our profession by being given a further mandate on the Board of Directors of the Canadian Nurses Association.



**Marian McGee, BNS (Queen's  
U), MPH (Johns Hopkins U)**

**Present Position:**

associate professor, Faculty of Nursing, University of Western Ontario, London.



#### Association Activities:

RNAO  
CNA—member, Special  
Committee on Nursing Research  
(1978-80).

#### Professional Affiliations:

American Nurses Association;  
American Public Health  
Association; Maryland Public  
Health Association; Canadian  
Public Health Association; Ontario  
Public Health Association.

**If one accepts the assumption**  
that all disciplines require a base  
set of knowledge/  
information-generating activities,  
then one must also accept the  
notion that these activities require  
nourishment, facilitation and a  
constant reinforcement of their  
legitimacy.

One of the payoffs that the  
Canadian Nurses Association  
should be able to realize in having  
a research committee (whose role  
is to attend to the care and feeding  
of the information-generating  
activities) is an increased  
probability that the knowledge  
base will be strengthened. The  
committee attempts to identify the  
fuel or funding sources, offer  
guidance in the use of  
mechanisms and methods for  
successful application and  
facilitate the diffusion of newly  
acquired information/knowledge  
to relevant sectors.

The executive and board of  
the Canadian Nurses Association  
can appropriately expect  
advisement on issues of  
methodology and analysis as the  
bases for many of their decisions.  
As they shepherd the disciplines  
into and through relationships of  
ever increasing complexity in the  
health care system, a high level of  
research literacy is required of  
them, and their constituents. It  
behooves us to be available to  
render necessary support.

## Candidates: Member-at-large, Social and Economic Welfare



**Mary Lou Annable, B.Sc. Nurs.  
Ed. (U of Ottawa)**

#### Present Position:

teaching master, Algonquin  
College, Ottawa.

#### Association Activities:

RNAO—Provincial Committee on  
Socio-Economic Welfare, member  
(1971-76) chairman (1976-78);  
member-at-large,  
Socio-Economic Welfare  
(1979- ); Board of Directors  
(1976- ); Ottawa West Educator  
Committee (1974- ); Executive  
Committee (1976-79).

**I believe that we as nurses are**  
*beginning* to take our well earned  
place in the economic structure of  
our country. But we have just  
begun and we must continue our  
efforts in this regard.

I am also concerned about  
nurses as social beings and  
believe we must pay increased  
attention to nurses as  
individuals—whether in our place  
of employment or in our role in the  
community.

As nurses we are frustrated  
with the quality and quantity of  
care we are able to provide our  
clients. We face the need to  
balance a heavy work load with  
the need to act as patient  
advocates and to be accountable  
as professionals for our actions.  
We add to this the need to update  
our skills to remain competent.  
While this may seem more than  
enough, we must also become  
more involved in health care  
decisions in the community.

I do believe that nurses must  
become more active. We must  
contribute as professionals, as  
citizens, and as employees.

As professionals, we must  
ensure that nursing continues to  
be attractive both to those already  
in the profession and to those  
considering it. As a profession, we  
must direct the factors that affect  
our social and economic welfare. I  
accepted the nomination for  
member-at-large, Social and  
Economic Welfare on the CNA  
Board of Directors because I  
believe I can contribute to this  
goal.



**Phyllis Goertz, BSN (U of  
Saskatchewan)**

#### Present Position:

coordinator, Special Nursing  
Projects, University Hospital,  
Saskatoon.

#### Association Activities:

SRNA—member-at-large, Council  
(1977-79); Committee on  
Chapters (1977-79);  
Saskatchewan Union of Nurses  
(1975-77); Provincial Negotiating  
Committee (1977-78).

#### Professional Affiliations:

Saskatchewan Union of Nurses;  
Canadian Nurses Respiratory  
Society.

**I believe that nursing care is a**  
critical component of patient care  
at every level of the health care  
system.

All levels of government feel  
the need to contain costs and  
health care is a major government  
expenditure. Nurses recognize the  
reality of this cost containment  
and are willing to work within  
reasonable constraints. Too  
severe restraint, however, affects  
the social and economic welfare of  
both nurses and their clients.  
Workloads must be such that not  
only are patients' needs met, but  
the nurses' needs for professional  
satisfaction are also met.

Standards are the key to  
resolving the conflicts at the  
interface of the nursing  
profession, the community, and  
the health care system. Once  
standards are set, the quality of  
care can be measured. Based on  
this measurement, discrepancies  
can be identified objectively and  
solutions explored. One of the  
roles of the CNA then, is to foster  
the development of nursing care  
standards wherever nurses work.

Nurses must work together  
presenting a unified front to  
promote the professional and  
personal goals of nurses. The  
CNA can be the catalyst for such a  
unified thrust.

I am eager to work with  
nurses from all over Canada and I  
am interested in becoming more  
involved with the issues in nursing  
by being the member-at-large for  
Social and Economic Welfare on  
the CNA Board.



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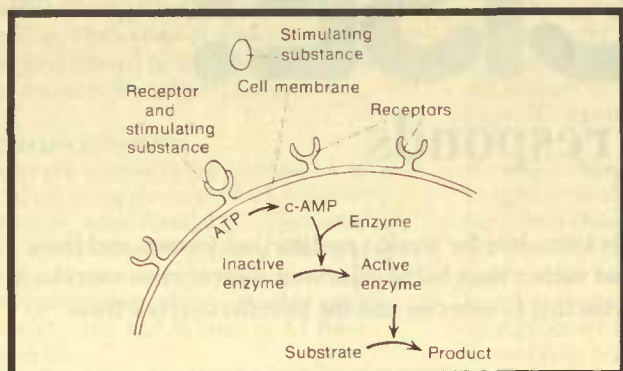


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# EXERCISE:

## How the body responds

Anne Hedlin

There was a time when post-myocardial patients were kept virtually immobile for weeks; postpartum women and those who had surgery were confined to bed for days. It is now known that rather than being injurious, appropriate exercise is actually beneficial. In this article, the author discusses the body's reaction to exercise and the benefits derived from regular physical activity.

No one system of the body operates in isolation: the skeletal muscles, the primary mechanism in exercise, are supported by several other systems to produce efficient muscle action. The central nervous system controls and gives direction to all skeletal (voluntary) muscle as well as regulating and coordinating cardiovascular and respiratory function to satisfy the increased demands of muscle during exercise. Subsequently, the cardiovascular and respiratory systems provide a ready supply of oxygen for energy production and to facilitate the removal of carbon dioxide and lactic acid following muscle activity.

Muscles adapt to the demands made upon them through daily exercise, by increasing in strength and efficiency to a level which satisfies the individual's lifestyle. Similarly a decrease in use will result in loss of tone and even atrophy. Consequently, the patient confined to complete bedrest for a few days could experience marked loss of muscle efficiency as well as a reduction in competence of cardiorespiratory performance, a loss of calcium from the bone and changes in body fluids.

### Oxygen supply

As the demand for oxygen increases during exercise several adjustments are made to meet the needs of the tissues. Oxygen diffuses from the lungs to the blood and then to the tissues only when there are pressure differences and only in the direction of high to low pressure. With inspiration of air, the partial pressure of oxygen ( $PO_2$ ) in the lungs rises to about 100 mm Hg resulting in diffusion of oxygen to the pulmonary capillary where venous blood  $PO_2$  is about 40 mm Hg. The  $PO_2$  in the pulmonary blood rises to 95 to 100 mm Hg and the oxygen is transported in combination with red blood cell hemoglobin to the tissues where again it diffuses in response to a pressure gradient, but this time the gradient is from the blood to the tissues (See Figure one).

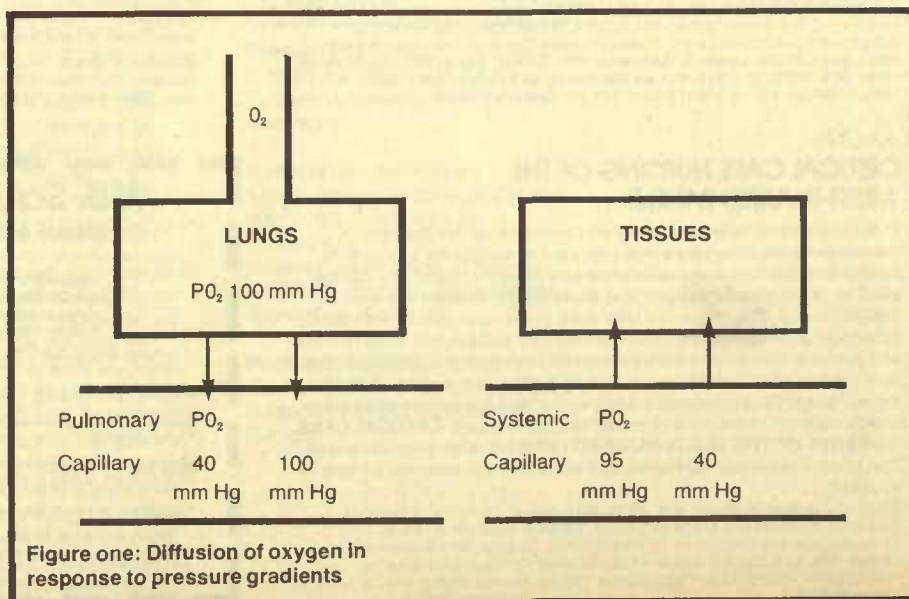
In exercise these diffusion gradients are increased; that is, more oxygen is being consumed in the tissues so there is a greater difference between the  $PO_2$  of blood and the  $PO_2$  of tissue. Therefore, more oxygen is given up by the blood; the  $PO_2$  of the venous blood falls below 40 mm Hg and remains there until it reaches the lungs again where its  $PO_2$  is restored to the 95-100 mm Hg level.

A second means of providing more oxygen to the tissues is through a change in factors which promote an increased dissociation of oxygen from hemoglobin. Hemoglobin, a molecule composed of the protein globin and an iron-containing pigment (heme) found in the red blood cells, provides the major means of oxygen transport as oxygen is poorly soluble in water, the liquid portion of blood. The oxygen dissociation curve (See Figure two) illustrates the relationship of hemoglobin saturation, partial pressure of oxygen and oxygen content (mls per 100 mls of blood). At "a", with a normal acidity (pH 7.35 - 7.40), a normal carbon dioxide content of blood and a normal body temperature,

the hemoglobin is 70% saturated with a  $PO_2$  of 40 mm Hg in venous blood. However, if the acidity or carbon dioxide levels are elevated or the body temperature increased, the curve will "shift to the right" resulting in lower hemoglobin saturation at the same  $PO_2$  (40 mm Hg), as shown at "b". Exercise causes the curve to "shift to the right" and the hemoglobin to give up more oxygen to the tissues. The  $PO_2$  may fall to as low as 20 mm Hg during strenuous exercise at which level the hemoglobin would be about 30% saturated having given up 70% of its oxygen.

Under normal conditions the arteriovenous difference of the oxygen level is about 5 mls per dl, that is, about 5 mls of oxygen per 100 mls of blood is given up to the tissues with each circuit. In exercise with venous blood  $PO_2$  falling below 40 mm Hg and a shift to the right of the dissociation curve, a much larger volume of oxygen is made available to the tissues.

As a result of exercise more oxygen is also provided to the tissues through local changes in blood flow. A rise in body temperature accompanied by an increase in carbon dioxide and decrease

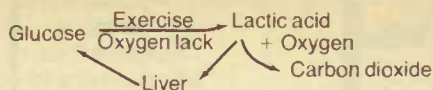




in oxygen level in the tissues, causes local vasodilation of the arterioles. This dilation of the vessels lowers resistance to blood flow and increases the volume of blood which reaches the working tissue. The extent of blood flow increase will be limited by the ability of the heart to increase its output of blood.

### Oxygen utilization

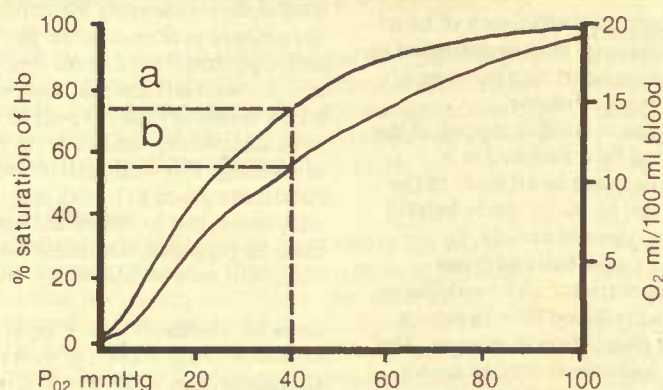
Oxygen is used in the production of energy from glucose which is stored in muscle in the form of glycogen and can be metabolized to provide energy in the form of adenosine triphosphate (ATP). If oxygen is present this is called aerobic metabolism and 38 units of ATP are formed.



The size of the oxygen debt will depend on the "fitness" of the individual and the type of exercise; with training the amount of the debt incurred through a specific exercise will decrease.

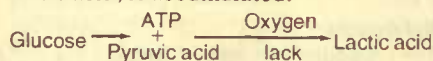
### Blood pH changes

In mild or moderate exercise there is very little change in pH (the hydrogen ion concentration) but with strenuous exercise the blood pH may fall a significant degree, primarily due to lactic acid production. During anaerobic metabolism lactic acid diffuses out of the cells into the blood where it reacts with



**Figure two — Oxygen dissociation curve** indicating the relationship of  $\text{PO}_2$  (mm Hg) to percentage of oxygen saturation of hemoglobin and oxygen transport in 100 ml of blood. The curve on the left represents oxygen dissociation under normal conditions. This curve is shifted to the right with exercise. At "a" with a  $\text{PO}_2$  of 40 mm Hg the oxygen saturation of hemoglobin is about 70% while at the same  $\text{PO}_2$ , with exercise, the saturation of hemoglobin falls to about 50%. Corresponding changes in oxygen content of blood can be determined from the vertical axis on the right side of the graph.

If oxygen is not available ATP can still be produced through anaerobic metabolism, but in this case the yield is only 2 units of ATP and the byproduct, lactic acid, is accumulated.



In mild or moderate exercise sufficient oxygen is usually available for aerobic metabolism but in strenuous exercise, the energy requirements may exceed the oxygen supply and by necessity ATP will be limited to that produced by anaerobic metabolism. If this anaerobic metabolism is prolonged a considerable amount of lactic acid will be produced and since oxygen is required for disposal of this lactic acid, an oxygen debt will be incurred. An oxygen debt is the amount of oxygen in excess of the resting level of  $\text{O}_2$  intake consumed at the end of exercise which is used to dispose of lactic acid. Lactic acid, in the presence of oxygen may be completely metabolized to carbon dioxide, yielding energy (as in aerobic metabolism), or it may be returned to glucose, through reactions performed in the liver.

sodium bicarbonate to form sodium lactate and carbonic acid, the sodium bicarbonate acting as a buffer to reduce the pH change. Carbonic acid can subsequently be broken down to form water and carbon dioxide, the latter being transported to the lungs for excretion.

Carbon dioxide, as well as being formed from lactic acid, is also being produced from aerobic metabolism. This may result in hypercapnia, excessive carbon dioxide in the blood, the degree being related to the severity of the exercise. If  $\text{CO}_2$  elimination is hindered, acidity will increase, that is, the pH will drop as hydrogen ion levels in the blood increase. However, normally the  $\text{CO}_2$  production and elimination are kept in balance and therefore, the major contribution to acidity is that of lactic acid and other acids and not to carbon dioxide.

### Respiratory contribution

The respiratory system is a major contributor during exercise, as oxygen is provided and carbon dioxide is removed through respiratory action.

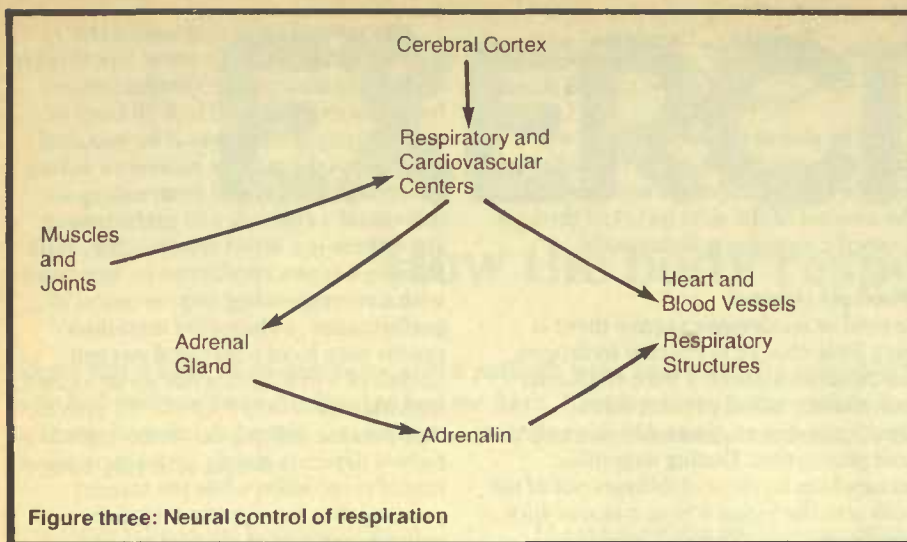
In normal quiet respiration the average adult breathes about five litres of air per minute (minute ventilation) and from this extracts 0.25 to 0.30 litres of oxygen (oxygen uptake). The maximal oxygen uptake may be measured during exercise as a means of determining an individual's efficiency of performance since there is a direct relationship. With training oxygen uptake can be improved, with a corresponding improvement in performance, a champion marathon runner may have a maximal oxygen uptake of 5 to 6 litres while an untrained man may have only 3 litres.<sup>1</sup> To provide this increase in oxygen, the untrained person depends mainly on an increase in rate of respiration while the trained person relies more on an increased tidal volume (amount of air exchanged with each breath).<sup>2</sup> Obviously, any interference with oxygen diffusion in the lungs such as lung disease, could seriously reduce the maximal oxygen uptake.

With exercise there is a change in the rate of respiration for which there is no clear-cut explanation. It does not appear to be due to chemical changes such as  $\text{PO}_2$ ,  $\text{PCO}_2$  or acidity. The arterial oxygen level does not decrease significantly in spite of the marked increase in consumption, in fact, with very strenuous exercise the  $\text{PO}_2$  may be slightly elevated. A build-up of carbon dioxide does not appear to be the stimulus as  $\text{CO}_2$  is eliminated as rapidly as it is produced and in strenuous exercise the  $\text{PCO}_2$  may actually be decreased. The acidity of arterial blood would not provide a stimulus either as in mild or moderate exercise it is either insignificant or absent.

Another reason to doubt that the respiratory stimulus is chemical in origin is that an increase in ventilation occurs long before there can be any change in blood chemistry. It has been shown that the respiratory rate increases as soon as exercise begins and also that passive exercises, in which the muscle isn't obliged to contract and therefore isn't producing  $\text{CO}_2$  or lactic acid, can induce respiratory changes.

It is now believed that the major control over respiratory activity during exercise is neural in origin. Anticipation of exercise will arouse the CNS, including the sympathetic nervous system, and may, by way of the motor cortex, hypothalamus and reticular formation, induce an increase in ventilation. Muscles and joints contain sensory receptors which send information to the respiratory centers in the CNS. This would explain the





increased respiratory activity with the onset of active or passive exercise. (See Figure three). The sudden increase with the onset of exercise, as well as the abrupt decrease in respiratory activity at the cessation of exercise also points to neural control as other controlling factors would be unable to adjust so rapidly.

This increased respiratory activity is associated with cardiovascular changes as the movements of the diaphragm and thorax during respiration promote venous return and the dilation of pulmonary capillaries results in an increased blood flow through the pulmonary system.

#### Cardiovascular adjustments

The efficiency of the heart in pumping blood to the lungs and working tissues is a limiting factor in exercise. If the muscle does not obtain a continuous supply of oxygen, its energy production will be decreased, and therefore its performance will be compromised.

The cardiac output, a measure of the heart's efficiency, is the product of heart rate and stroke volume (amount of blood ejected with each contraction), that is,  $\text{Cardiac output} = \text{Heart rate} \times \text{Stroke volume}$ . This is normally 5 to 6 litres per minute.

At rest a heart rate of 72 per minute and a stroke volume of 70 ml provides a cardiac output of 5040 ml. During strenuous exercise this may rise to 25,000 to 30,000 ml, a 5 to 6 fold increase. With mild or moderate exercise the predictions about cardiac output are more difficult as it is not necessary to have simultaneous increases in heart rate and stroke volume. Moderate exercise may produce an increase in either one or the other. It is believed that the untrained person tends to rely on increases in heart rate while training promotes an increase in stroke volume.

In fact, the improved efficiency of heart action, with training, may be reflected in a reduced resting heart rate because of an increased stroke volume.

An increase in cardiac output, if the increased blood flow resulted in a proportional increase to all parts of the body, would not be particularly helpful in providing oxygen to muscle. In exercise, the sympathetic nervous system vasoconstrictor and vasodilator activity shifts the blood flow to send a much greater proportion to muscle. The extent of the increase is related to the severity of the exercise. Resting muscle receives about 25 per cent of the cardiac output of 1200 ml per minute; in light exercise this increases to about 4500 ml, and in maximal exercise to about 22,000 ml out of a 25,000 ml cardiac output. This increase to muscle is at the expense of blood flow to some tissues but exceptions are the heart and brain. The heart receives increasing volumes of blood with increasing cardiac output but brain blood flow remains constant.<sup>4</sup>

The increased blood flow in muscle is associated with a dilation of the muscle arterioles and opening of many capillaries which would otherwise be closed. This shortens the distance for oxygen diffusion to the cells. An increase in the capillary flow also results in a greater movement of fluid into the muscle tissue and a reduction in blood volume or hemoconcentration. This increased movement of fluid into the muscle contributes to the stiffness of muscles experienced by the untrained person who exercises too zealously.

Blood pressure, primarily systolic pressure, rises during exercise due to the increased cardiac output and sympathetic nervous system activity. There is little change in the diastolic pressure and in fact, if there is extensive peripheral vasodilation in tissues such as muscle, the diastolic pressure may actually decrease.

#### Body temperature change

The increase in metabolic activity causes an increase in body temperature since about 80 per cent of the energy expenditure is in the form of heat. To dispose of the heat generated by exercise the skin blood vessels open and deliver heat to the surface so it can be dissipated.

Most athletes "warm up" before their performance as a means of improving their efficiency. By increasing the temperature in the tissues the oxygen dissociation curve will be shifted to the right so more oxygen can be unloaded in the tissues.

#### Effect of inactivity

The harmful effects of lack of exercise are not confined to patients. The person who leads a sedentary life cannot expect to compare in fitness to the physically active person. Nor can the one-time athlete, who left athletic competitions to lead a sedentary life, expect to perform at an athletically-trained level without re-training. Physical activity can contribute much to health and well-being, but to obtain the benefits one must be prepared to commit both time and effort on a regular basis. ♣

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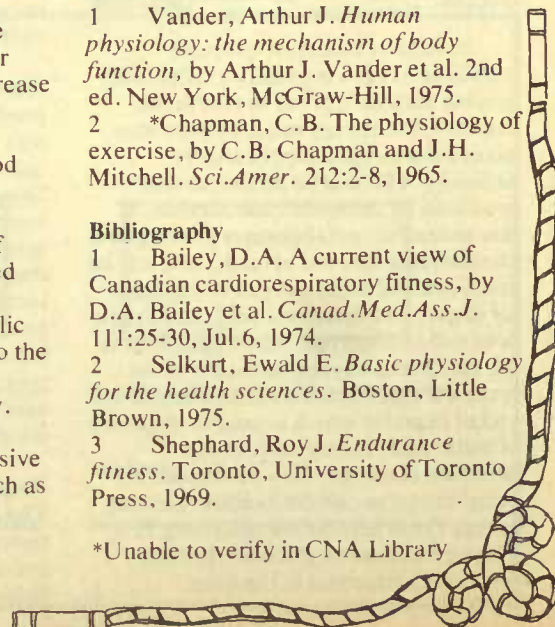
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Is the current high level of interest in physical fitness simply a passing fad? I don't think so. Who can forget the excitement in the late 1950's when the Royal Canadian Air Force Pamphlets 5BX and 10BX became international bestsellers? It may also be difficult to accept, but Participaction's famous 30-year-old Canadian and 60-year-old Swede will turn 38 and 68 respectively in 1980, and it really was six years ago when the Lalonde White Paper "A New Perspective on the Health of Canadians" put "lifestyle" into our professional vocabulary. And yet, the question is still being asked, "Where does nursing fit into physical fitness?"

Nurses, as health professionals practising across the whole health care spectrum — education, assessment, prevention, treatment and rehabilitation — have a special responsibility and are in an ideal position to provide leadership in the promotion of physical fitness. They can contribute through:

- provision of information and counseling in school, occupational and public health settings;
- initiation and operation of fitness programs in schools, hospitals, offices, plants and communities;
- personal example, by attitude toward and participation in exercise programs.

In whatever capacity a nurse intends to meet this responsibility, it is important to have a perspective and understanding of the scope of fitness, the benefits of exercise and the components of an exercise program so that each individual nurse may select a role to meet her responsibility of fitting into fitness.

### The Scope of Fitness

The foundation of physical fitness is contained in the World Health Organization definition of health as a state of physical, mental and social well-being, and not just the absence of disease or disability. Although I will focus on the exercise component of a fitness program, it is extremely important to recognize that the concept of physical fitness embodies the examination of the whole of one's lifestyle for factors that may contribute to a lowered state of health. Integral to an overall fitness program, therefore, will be the capacity to assess and counsel individuals on adequate medical and dental care, nutrition, rest and relaxation, adverse work environments and excessive use of drugs, alcohol and tobacco.

The physical, physiological, psychological and social benefits of an exercise program have been well recorded.<sup>1,2</sup> (See box) Taking these into account, a physical fitness program should ultimately provide the individual with an ability to carry out daily tasks with vigor and alertness, without undue fatigue, and with ample energy to enjoy leisure time activities and meet unforeseen physical demands.<sup>3</sup> Fitness varies among individuals and within the same individual at different times in life. It is a dynamic state rather than a static one and must be maintained by regular and frequent challenges and assessment.

The objectives of a fitness program should therefore aim to: develop more energy to meet daily needs, remove aversion to physical work and participation in sports or exercise, develop

# Fitting nursing into fitness

E. Lee Macnamara



primary components of fitness (cardiorespiratory endurance, muscular strength and endurance, flexibility, agility, balance, power, coordination, speed and per cent body fat composition), promote relaxation, improve overall outlook and personality, protect the body against suddenly imposed stress, aid in weight control, slow down the aging process and physical deterioration, e.g. arthritis, and protect against premature heart disease, low energy capacity, back problems and premature failure of all physiological systems.

While all of the above deserve attention in an exercise program, the most important from a preventive perspective is cardiorespiratory fitness as measured by the maximal oxygen uptake, that is, the body's capacity to supply oxygen to working muscles.

### Approaching Exercise

Notwithstanding the long term benefits to be derived from an exercise program, the following are **absolute contraindications to exercise**<sup>4</sup>:

—congestive heart failure, acute myocardial infarction, active myocarditis, angina pectoris with effort, dissecting aneurysm, recent systemic or pulmonary embolism, thrombophlebitis, ventricular tachycardia or other dangerous dysrhythmia, severe aortic stenosis, and acute infectious disease.

Prior to undertaking an exercise program, a medical examination will eliminate reasons precluding participation and a fitness evaluation will provide a baseline against which progress can be measured.

An exercise program should not be seen as a competition. Participants should begin and proceed slowly lest a muscle or

Warm-up



Light exercise





ligament strain cause discomfort and discouragement. Exercise sessions should be performed at regular intervals (initially at three and rising to five times per week), should begin with a warm-up period and end with a cool-down period. Proper clothing will permit free movement. Since proper footwear is most important, seek advice on footwear from a fitness counselor or instructor.

### Quality and quantity of exercise

The American College of Sports Medicine recommends the following guidelines for developing and maintaining cardiorespiratory fitness in healthy adults.

1. *Frequency of training:* initially three days increasing to five days per week.
2. *Intensity of training:* 60 to 70 per cent of maximum heart rate (MHR) [MHR = 220 minus age in years]. For example, for a 40-year-old, initial training intensity should not permit heart rate to exceed  $0.7 \times (220-40)$  i.e.  $0.7 \times 180 = 126$  beats per minute but should reach a lower level of  $0.6 \times (220-40)$  or 108 beats per minute.
3. *Duration of training:* 15 to 60 minutes depending on the intensity, i.e. the lower the intensity of training, the longer the period of training permitted.
4. *Type of activity:* any activity that utilizes the large muscle groups, is continuous in nature and raises the heart rate to the desired level.
5. *Monitoring heart rate:* radial or carotid pulse should be monitored before, during and after exercise (count for 10 seconds and multiply by six). Pace or intensity should be adjusted to bring heart rate into target range.

### The exercise period

Whether you are involved in your own personalized exercise program or an organized one, a typical 35 to 40 minute exercise period should include the following steps.

- A warm-up (5 minutes) which includes large muscle movement to prepare the body for exercise.
- Light exercise (5-8 minutes) including flexibility, bending, stretching, balance and coordination.
- Heavier exercise (5-8 minutes) involving a work-out of legs, arms, shoulders, back and abdominal muscles to develop strength and endurance.
- Cardiorespiratory exercise (15-20 minutes) the peak period of a work-out to promote conditioning of heart and lungs, utilizes rhythmic exercise such as running, brisk walking, skipping, bouncing, skating, cross-country skiing and rowing.
- The cool-down (5-8 minutes) is facilitated with slow easy movements to allow the body to return to the resting state.

### Special programs for special people

The above guidelines are those recommended for healthy adults. The benefits of exercise can be extended to special groups and indeed special fitness programs including lifestyle instruction, have been developed and are operating successfully

for post-coronary patients, asthmatics, the physically and mentally handicapped, pre and post natal, the overweight and chronic back pain sufferers.

By understanding the basic physiology and pathophysiology underlying these conditions, the basic exercise program may be adjusted to strengthen weakened muscles and improve cardiorespiratory endurance as in a post coronary program or adjusted to strengthen muscles which will be required to increase their workload, such as the perineal, abdominal and lower back muscles in the prenatal state.

It is in these programs that the nurse can be particularly valuable as an instructor. In addition to understanding the conditions, their pathology and therapy, the nurse is also familiar with possible emergencies and their treatment. The very presence of a nurse can provide the participants with additional confidence in both the environment and the program. As well, the nurse's experience in maintaining a rapport with persons concerned with their health is an added "plus".

### Fitting into fitness

As I suggested earlier, nurses are in an ideal position to provide leadership in the promotion of physical fitness in the course of their normal practice. However, for those who wish to be more directly involved as 'fitness instructors', obtaining the necessary qualification through a Community College or YM-YWCA course is a prerequisite. Although the opportunities for full-time employment are limited, exercise programs are often largely community sponsored and based on the participation of volunteers or part-time employees.

Information on fitness programs can be obtained from a variety of sources including the local YM-YWCA, municipality sports or recreation departments, community centers, private 'Fitness Institutes', businesses or industries operating employee fitness programs or university departments of physical or sports medicine.

In conclusion, the nurse has an important role in the promotion of physical fitness as a counselor, advisor, instructor or — most important — as an example. This responsibility can only be discharged by obtaining an appropriate understanding of the scope, purpose, benefits, contraindications and components of a properly planned exercise program, followed by a personal decision on where to fit into fitness. ♡

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Heavier exercise



Cardiorespiratory exercise





# WHAT'S IN IT FOR ME?

Television, radio and newspapers are all inundating us with demands to get fit, to stay young, to get out and enjoy life. Do you respond by promising to start next week, or when your cold is better, or after you have lost 15 pounds? Or excuse yourself by saying that you are too old or just no good at that sort of thing?

Everyone knows that exercise is beneficial and works many wonders but here's what it can really do for you!

## Physical Benefits

- increased muscle tone, power, strength and endurance
- increased range of motion and coordination
- reduction of stiffness, fatigue, weakness, incoordination
- facilitation of good posture and flexibility

## Physiological Benefits

- reduction of heart rate and blood pressure, increase in stroke volume
- reduction in serum triglycerides and free fatty acids, some reduction in serum cholesterol
- improved pulmonary and cardiovascular function i.e. increased exercise and work tolerance at less oxygen cost
- a factor in prevention of obesity — redistributes body fat
- improved sensory perception and motor response
- decreased incidence of degenerative disease
- retardation of physical and mental effects of aging
- prevention of cardiorespiratory and cardiovascular disease (in post-coronary patient helps develop supplementary capillary vessels)

## Psychological Benefits

- relief of tension, stress, frustration and aggression
- improvement of self-confidence, improvement of attitude and mood
- promotion of relaxation and encouragement of emotional and social adjustments

## Social Benefits

- development of activities for daily living, life skills
- meeting ground for social interaction (team and individual sports)
- an aid in rehabilitation of psychiatric disorders — self expression, social integration with a group, relaxation
- rehabilitation of hemiplegics, paraplegics and amputees is accelerated when patients respond to physical activity.

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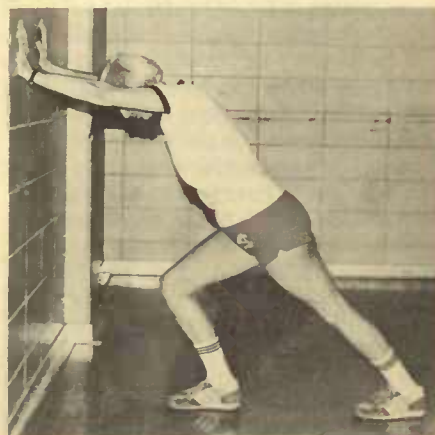
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*Cool-down*





If hospitals have a responsibility to promote preventive health measures among their patients, do they not also have a responsibility to encourage their own staff in this direction? To date, only a handful of Canadian hospitals (less than ten in Ontario) have accepted this challenge. Here is the story of one of these — the ups and downs of establishing and maintaining a fitness and lifestyle program in a large and complex institution.

# An employee Fitness Program



## Hospital Style

Janet McEwen

• Every year, billions of dollars are spent on our illness-oriented health care system. A recent provincial government study estimated that 31 million Ontario Hospital Insurance Plan dollars could be saved annually if all adults had at least an average level of fitness, ie. they were not overweight and under-exercised.<sup>1</sup>

• In 1975, Canadians lost 745 million production hours through sickness, tardiness, fatigue and casual absenteeism. The cost, in terms of wages, salaries and other payments for work not performed, is estimated at close to 4 billion dollars. More than eight times as many man-days were lost through absenteeism than through strikes.<sup>2</sup>

Is there a relationship between these two sets of figures? In 1977, a two-year comparison study of individuals participating in the Metropolitan Life Fitness Program indicated beneficial effects for the participants in terms of health, favorable lifestyles and attitudes. Among the benefits from the *company's* point of view were improved morale, performance and a decline in absenteeism.<sup>3</sup> These results have been corroborated by Canada Life Assurance which, in 1979, published initial findings from an experimental fitness program.<sup>4</sup> Physiological post-program results demonstrated significant improvement in body flexibility, decreased absenteeism and more positive attitudes towards health. Other studies have also reported finding that, in addition to definite

physiological benefits, an increase in well-being, morale and company rapport is evident.

In these days of budgetary restraints and financial cutbacks, are these statistics not sufficiently convincing to persuade hospital administrations of the positive effects of fitness programs? Some hospitals *are* making attempts to establish programs, but the task is not an easy one. I would like to briefly describe the steps we have taken at the Ottawa Civic Hospital in the development of our employee fitness program.

• **June, 1978.** The Canadian Public Health Association, with Loto Canada funding, placed 50 kinanthropology students in institutions across Canada in an attempt to initiate fitness and lifestyle programs. Throughout that summer I worked with our student to establish a program at our hospital. Together we: —organized an exercise facility in a recreation area of the nurses' residence —arranged for shower and change facilities —designated a Fitness Promotion area outside the cafeteria for dissemination of lifestyle literature —published a bi-monthly newsletter —organized film and lecture presentations on topics related to fitness and lifestyle —established fitness testing with the facilities of a YMCA van and —sold fitness T-shirts.

My secretary and I, both certified fitness instructors, organized two exercise classes which we held after working hours. My class from 1530 to

1630 hours primarily attracted nurses, the majority being head nurses and those with consistent hours, while the 1630 to 1730 hour class attracted employees from lab medicine, other allied health professionals and secretaries. Bicycling and jogging clubs were established, mileage charts were placed outside of the cafeteria in the fitness promotion area and crests were awarded for attainment of specific mileage milestones.

• **September, 1978.** The hospital administration decided to retain the original student, and, as well, hired a second university student, both on a part-time basis to assist with continuing the program. An Administrative Assistant was appointed to coordinate the program and the four of us met weekly to plan and organize activities. During this period, we received consultative services from an employee fitness consultant from Fitness Ontario. Over the next few months our programs grew and enthusiasm seemed contagious.

• **October, 1978.** Our first ten-week exercise programs were completed and we celebrated with a dinner for all participants featuring a speaker on aerobic exercise and the presentation of awards. Fun, commitment and enthusiasm were obvious. We continued the two afternoon programs with an enrolment now of 70, and a noon hour program was added for employees who were able to take an hour for lunch, thus eliminating the nursing population.

• **December, 1978.** The completion of another program series was celebrated



with a wine and cheese party and an awards presentation. This time questionnaires were completed. Participants indicated that they were enjoying the program, feeling decreased stress levels, increased energy, increased awareness of their lifestyle, improved sleep and digestive patterns, increased flexibility and more positive self images.

- **January, 1979.** Just over 100 employees registered in the three fitness classes. Ski lessons at a local ski center and yoga classes were also organized. A hospital-wide survey indicated sufficient interest to continue and expand the program. With the resignation of one of the part-time students, a committee of volunteer employees was established to carry on promotion, operation and finance functions. Promotion continued through noon hour presentations, newsletters and distribution of lifestyle literature.

- **April, 1979.** Approximately 200 employees registered in three exercise classes, disco dancing, women's self defence, yoga and behavior modification for weight control, the latter programs taught by community instructors. Twenty employees, including nurses, x-ray and lab technicians, an orderly and a secretary, registered in a Fitness Instructor's course which I taught under the direction of a local University Athletic Center. Eleven employees graduated from this program.

Another successful social event was held, this time featuring a pot-luck vegetarian dinner contributed to by employees, a lively presentation by a dietitian, and, as was becoming customary, the presentation of awards. Many came expecting radishes and carrot sticks and were quite amazed at the assortment of tasty casseroles and salads available. Our social event was the talk of the cafeteria the next day. At this time our second fitness student resigned and the Carleton University Athletic Centre was established as a consulting service.

The program reached its "high" point at this time. The noon hour program was probably the most popular and the growing number of management participants, including three medical department heads, lent credibility to the program. It was most gratifying to see participants from all areas and levels of the hospital staff having fun together. No longer was the Chief of Nephrology a physician, he was now "Gerry", jogging in his shorts and T-shirt with the group. It was interesting to see the Chief Purchasing Officer doing the "polka" with the Infection Control Nurse, the Director of Plant Operations jogging with the Director of the Admitting Department and the Chief of Cytology helping his fellow laboratory technicians with their stretching exercises. An

Photos courtesy of the Ottawa Civic Hospital, Ottawa



amusing anecdote resulted from one of our Spring jogging sessions: the Director of Psychiatry noted that if any of his patients saw him "tiptoeing through the tulips", they would wonder which one of them required treatment.

During the summer, formal classes were discontinued but we attempted to maintain interest through individual bicycling and jogging clubs.

- **September, 1979.** The program was dealt a serious blow when our location was taken over for the new Ambulatory Care Facility. We submitted a proposal for a new area in another basement area of the hospital, but this was rejected due to the demands of the hospital's redevelopment program.

This was the "low" point of the program. It would have been so easy just to discontinue the whole project — our budget was depleted, we had no outside assistance, our new fitness instructors had no place to practice their new skills and some of our good volunteers had either left the hospital or indicated lack of interest due to the lack of facilities. At this point, my personal commitment was also sorely questioned, as I was feeling increased demands in my own job. However, with the excellent support of the small group of remaining volunteers, we decided we could not abandon the project after all the efforts of the past year.

Space was found in our Education Building to continue the 1630-1730 hour class and new shower and change rooms were established in the "redeveloped" nurses' residence. We were allotted a room for exercise, but it was too small for the large formal classes, so it was only used by the individual noon hour joggers for a warm-up and cool-down area. Even this activity was relatively unsuccessful as former participants missed the group spirit.

We decided to increase our emphasis on our weekly noon hour educational program.

- **November, 1979.** A series of six lectures on stress management brought several interesting comments. An aide in the OR instrument room stated "The program came at an excellent time for me. I was having personal problems and I learned some new techniques to help me deal with them." The Business Manager of the Cancer Clinic commented, "The program helped me to understand the physiological effects of stress, methods of relieving stress and made me aware of identifying stress related staff behaviors."

Also in November, a Fitness Promotion Advisory Committee was established which I chair and includes representatives from the Fitness Promotions Committee, dietetics, physiotherapy, nursing education, media coordination, social service, cardiac rehabilitation, occupational therapy, health service and the recreation committee. The goals of this committee are to coordinate fitness and lifestyle education with other hospital programs, to collaborate on how to present monthly themes and to improve communication about our programs throughout the hospital.

At this time our fitness program was placed under the administration of the Director of Personnel. We continued fitness promotion through literature and newsletters, a "design a logo" contest was held and a new logo established. Plans were made to start a back program for the Housekeeping staff in January. This was to be given by the employee health nurse who had attended a "healthy back" instructor's program at the local YM-YWCA.

- **December, 1979.** Former participants complained that they were really missing the classes, were not feeling as well and were gaining weight. The Chairman of the Promotions Committee and myself felt we could no longer carry the load on a volunteer



basis, so I prepared a submission to our Executive Director requesting that a part-time fitness consultant be hired to attempt to rejuvenate the program within the boundaries of the existing lack of exercise facilities.

At the time of compiling this short history of our program, a graduate of the B.Sc. Kinesiology program of the University of Waterloo has just been hired on a part-time basis. Due to the small size of our facility we have increased the number of fitness classes being offered. To date we have registered 85 people and our newly trained fitness instructors will be utilized in teaching the programs. The only other program we have offered is disco dancing, but registration so far has been poor; actually interest in disco dancing seems to be waning and belly dancing might have proved a more popular choice.

Our new consultant is currently conducting individual fitness appraisals for each registrant in the fitness classes and he will also assist with educational presentations on heart disease and exercise for our February heart month educational program. In March, the physiotherapy department with his assistance will present a "prevention of back injury program" for all employees. Plans are being made for a primarily audiovisual presentation that will be readily accepted by the various ethnic groups employed. Photos of faulty lifting and work methods are now being taken in the housekeeping, dietetics and laundry departments (we already have many slides of these poor techniques in nursing) for use in the presentations. It is expected that the program will be presented at least 60 times with at least one course in Italian.

We also foresee our consultant cooperating with the employee health nurses in planning back exercise programs, weight control programs and implementing "exercise breaks". Thus a whole new dimension to the employee health nurses' role may be opening up. Their enthusiasm for this is evident.

Finally, we hope that our fitness consultant can work with the architectural planners to make the dream of a new fitness center a reality.

So that is the story of one hospital's difficult, but rewarding activities along the road to developing an ideal program. We are not close to that point yet, but I feel hopeful that the ground work has been laid.

My work with the program has been an excellent learning experience. A few suggestions for those attempting to establish programs would include:

1. *Adequate personnel to provide leadership.* In an institution as large as ours, I do not feel this can be done totally on a voluntary basis, however volunteer leadership participation must be

## What About Nurses and Fitness?

On the strength of her own personal experience and commitment to fitness, author, Janet McEwen, comments: "At the Ontario Hospital Association fitness conference, most hospitals with established programs indicated that they were having difficulty enticing nurses to participate. Whether this phenomenon is due to shift changes, fatigue or feelings that sufficient physical exercise is done during the working day, we also found that most of the few staff nurses who enrolled in our classes dropped out as their shifts changed, leaving only the Head Nurses as our regular participants.

I would like to encourage all nurses, management or general staff, to participate in some type of exercise and lifestyle program whether at work or in the community. A personal commitment to a more active and healthier way of life is the first step in fulfilling our role as lifestyle educators."

provided by energetic committed employees. Contributions from departments associated with preventive health (e.g. Health Service) is essential, as is inter-departmental communication and cooperation.

2. *Facilities.* A well organized, sufficiently large, preferably onsite facility which is safe and well-equipped, including adequate shower and change rooms, is a necessity.

3. *Administrative support.* Fitness programs belong under the umbrella of Personnel Administration and will probably not survive without the interest and support of the Executive Director.

4. *Research.* A survey of employees is essential to determine interest in participation and providing leadership, the type of programs wanted and the times suitable.

5. *Budget.* Employees may be charged small fees for classes, but usually this will not finance the entire program. The institution must assume the responsibility of committing some funds for ongoing operational and equipment expenses.

6. *Program.* The exercise program should be based on the latest scientific principles (sufficient warm-up, static stretching, aerobic period and suitable cool-down). Adequate consultation with exercise physiologists should be utilized and exercise leaders, preferably from within the hospital, should be trained under their direction. Fitness education can be included in the classes and music, variety and fun are important components, as are social events and motivational gimmicks. In addition to exercise, classes geared towards back pain and weight control are important.

7. *Program evaluation.* Quantitative and qualitative measures should be developed to determine if established objectives are being met.

8. *Promotion.* Lifestyle awareness must be kept alive with promotion through literature, newsletters, posters, films, speakers and most importantly personal encouragement. \*

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**Janet McEwen, BScN, Ed.,** has held both teaching and administrative nursing positions and is presently Director of the Registered Nursing Assistant Program Ottawa Civic Hospital. Janet's commitment to fitness stems from a car accident several years ago, after which her prognosis for future involvement in athletic pursuits was poor. Two years of personalized exercise programs, physiotherapy, support and encouragement and lots of hard work has left Janet fitter than ever. She has assumed a volunteer leadership role with the Ottawa Civic Hospital Fitness Program, holds two fitness instructor's certificates, and is a committed runner having completed her first 26-mile marathon in 1979. Janet also enjoys cross country skiing, canoeing, backpacking and playing tennis.

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# The Stress Test

**The cardiac patient who is trying a treadmill or stress test for the first time is often extremely anxious because he doesn't know what to expect. Does his nurse?**

The physician today frequently uses the services of a "non-invasive lab" to assist him in the diagnosis of cardiac disease. The tests performed in such a lab include stress testing, ambulatory monitoring and cardiac ultra-sonography. No test requires that a patient be hospitalized, although these tests are often ordered during hospitalization. Since the skin is not punctured during any test the name applied generally to this group of diagnostic services is "non-invasive". The nurse has an important role in such testing, both in preparation and monitoring of the patients.

There are both diagnostic and therapeutic implications in performing a stress test. The procedure may be ordered by the physician as a means to document an episode of cardiac ischemia or to determine the physiological mechanism causing angina, functional valve incompetence or extreme rise in blood pressure in a particular case. Therapeutic reasons for stress testing include documentation of the response to medical or surgical treatment and determination of the functional capacity of the patient for work, sport or participation in rehabilitative programs.

## Principles of stress testing

### *Dynamic vs Isometric exercise*

All stress tests — whether step, bicycle ergometer or treadmill — follow the same principles. The tests are aerobic in design which means that they all measure the amount of oxygen consumed by the heart muscle. The tests are designed to utilize dynamic rather than isometric exercise. In dynamic exercise a large muscle mass (the legs) moves without a significant resistance; dynamic exercise increases cardiac output which in turn increases the transport of oxygen. Isometric exercise, on the other hand, where the muscles move against a resisting force, increases the blood pressure without significant increase in cardiac output.

Patricia MacFarlane

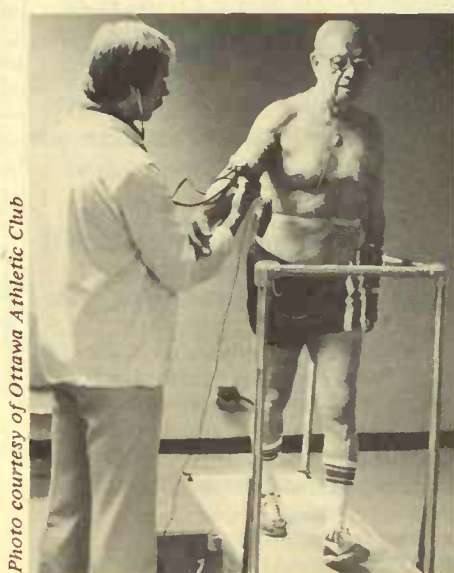


Photo courtesy of Ottawa Athletic Club

Not all patients can undergo stress testing; those who may exhibit clinical signs of congestive heart failure because the left ventricle of the heart is already stressed beyond its capacity are excluded, or those with obstruction of the left ventricular outflow tract as in restrictive cardiomyopathy. Patients with severe chronic obstructive pulmonary disease (COPD) will be unable to perform aerobic exercise to any degree. Patients with severe peripheral vascular disease or acute myocardial ischemia are also excluded. Patients with certain musculoskeletal limitations as in CVA, ataxia or multiple sclerosis are not suited for stress testing.

Electrocardiographic findings which exclude patients from stress testing are uncontrolled arrhythmias such as atrial fibrillation with uncontrolled ventricular response, PAT, junctional rhythm, A-V block and ventricular arrhythmias. Other indications are acute ischemic changes and ECG changes due to digoxin, quinidine compounds or the use of diuretics.

### *Establishment of endpoints*

The duration of a test is generally not longer than 15 minutes; this time limit prevents having to discontinue the test due to leg fatigue rather than cardiac indications of stress. A pre-determined set of endpoints is established in each lab; the endpoints are divided into two groups, clinical and electrocardiographic.

### *ECG determinants for endpoints are:*

- ST depression 1.5 mm or greater
- ST segment elevation
- PVC's (multiple pairs, multi-focal, bigeminy)
- ventricular tachycardia, fibrillation
- supraventricular tachycardia
- advanced heart block.

### *Clinical determinants are:*

- chest pain
- severe dyspnea
- syncope
- dizziness
- excessive fatigue
- abnormal blood pressure (systolic  $\geq$  260 mm Hg, diastolic  $\geq$  110, or a systolic drop of 20 mm Hg)
- severe musculoskeletal pain (claudication)
- patient's desire to stop.



### The test itself

The patient should fast and refrain from smoking for two hours prior to taking the test. Comfortable clothing such as shorts or slacks should be worn and well-fitting footwear is a necessity for safety while exercising. Slingback shoes or slippers increase the chance of the patient losing his balance during the test.

Due to the slight risk involved every patient should be required to sign an informed consent after the procedure has been explained to him to his satisfaction. The stress lab must have emergency resuscitation equipment close to the testing area and a qualified physician within two minutes call.

Electrodes are placed on the chest in accordance with the 12 lead cardiogram positions. The test begins at a workload far below the estimated level of cardiac impairment. The patient is then able to "warm up" to the exercise while becoming familiar with the equipment. Starting at a low level will help to limit an episode of angina due to nervous tension.

The test proceeds according to the protocol chosen by the physician. The various treadmill protocols deal with the combinations of elevation and speed of the treadmill. In the Bruce protocol, for example, the speed and elevation increase at three-minute intervals until an endpoint is reached.

Whichever test is chosen, it is important that the patient understand what is expected of him. A demonstration of the procedure by the technologist will help to clarify any questions. If time permits the patient may try a short walk on the treadmill. When a patient feels comfortable with the procedure he is able to maintain a constant level of work thus giving a standardized response to each exercise level. If someone finds he cannot walk at a constant speed a metronome may be used to set the pace.

It is important that the blood pressure, heart rate and electrocardiogram be monitored before, during and after exercise. The parameters measured prior to the test determine whether the patient is able to perform the test. The blood pressure and pulse are measured at the end of each exercise level to determine if the heart is performing satisfactorily. During the recovery phase these parameters should return to the baseline measurements. In the Bruce protocol it is expected that measurements will return to the baseline levels in six minutes; the recovery period is extended if these levels are not reached in that time.

### Exercise physiology—what's normal

Four factors influence the cardiovascular response to exercise: (1) type of exercise (2) duration of exercise (3) age of individual and (4) environment.

As the body ages certain physiologic changes occur: the stroke volume of a twenty-year-old man is greater than that of a seventy-year-old. Due to the aging of the lungs, less oxygen is transported across the alveolar membranes thus reducing the amount of available oxygen.

Stress testing must be carried out in a controlled environment. If the temperature is too hot, the patient's resting heart rate will be higher, stroke volume and blood pressure will be lower and the tone of the capacitance vessels (large veins in the thorax and abdomen) will be less. The body tries to keep its temperature constant and responds by increasing the flow of blood to the skin, causing the patient to perspire. On the other hand, if the testing room is too cold the heart rate and cardiac output will remain unchanged but the blood pressure will increase due to cutaneous vasoconstriction.

In upright dynamic exercise, the vascular system undergoes certain changes as it adapts to the increased workload. Here's what happens:

- Arterial blood vessels dilate, causing a fall in peripheral resistance (an initial drop in blood pressure may be seen).
- The body's blood supply is redistributed to increase cardiac output; blood is diverted from the spleen, stomach, etc.
- Venous return increases.
- There is constriction of the capacitance vessels to increase flow of blood to the heart.
- The increased flow of blood to the heart increases stroke volume.
- Increased stroke volume increases strength of muscle contraction (Frank-Starling law).

### Exercise physiology—what's abnormal

There are two abnormal physiological responses that can be measured during exercise testing. There may be a drop in systolic blood pressure due to inotropic incompetence of the left ventricle: the left ventricle is unable to contract efficiently and the systolic pressure falls. Auscultation of the heart at this point would reveal the presence of a gallop rhythm. Abnormal precordial motion may also be seen.

The other abnormal response relates to heart rate. A patient with severe coronary disease may rapidly increase his heart rate at low workloads. Due to lack of contractile muscle tissues, the heart functions at a fixed stroke volume. To increase cardiac output the heart rate must increase quickly. The heart rate will quickly reach a plateau and only a minimal increase will occur at higher workloads. If the exercise is continued this minimal increase is usually followed by a drop in heart rate.

### The positive stress test

If the stress test is positive the electrocardiogram may show one or all of the following abnormal responses: ST segment depression or elevation, conduction disturbances and arrhythmias.

The patient may experience chest pain, faintness or dyspnea. He may also exhibit signs of pallor, cyanosis and cold sweat. When the heart is auscultated murmurs or gallops may be heard. Hemodynamic changes usually occur if an artery is 75 per cent or greater occluded.

When reviewing the positive stress test the physician must take into consideration the duration of the test (patient's functional capacity) and the time of onset of clinical signs. A patient with a mildly positive stress test may benefit from a rehabilitative exercise program. Regular, supervised exercise will help the patient to reduce stress and tension, lose weight and increase exercise endurance.

A patient with a moderately or strongly positive test may need further investigation such as coronary angiography to determine the extent of the disease. ❖

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# Cardiac rehabilitation:

## applying the benefits of exercise

For many years exercise testing has been used

*Barbara Naimark*

The Winnipeg cardiac rehabilitation program got underway in 1973 with five post myocardial infarction patients. The program grew rapidly and soon included individuals, post infarct and following aorto coronary bypass surgery, as well as those with stable angina pectoris. As it grew, it became evident that systematic and regular exercise resulted in significant improvement not only in the work capacity of the individual but also in the general ability of that person to cope with his disease in psychological terms.

Initially, the program facilities were housed in the bowels of a physical education building at the University of Manitoba, affectionately termed the "gritty grotto". These facilities soon became inadequate and with the help of the Kinsmen Club of Winnipeg, private donors and government support, new quarters were built. In February, 1979, the program moved to these quarters — a spacious, airy, temperature controlled

to measure the functional capacity of persons with cardiac disease.

A more recent development has been the systematic use of physical training as part of the rehabilitation of these individuals.

While much remains to be learned about the long term benefits of this form of rehabilitation, the short term benefits are often striking and have stimulated increasing interest among those involved in the management of cardiac problems.

center consisting of a 200-meter, four lane track with a uniturf surface, hardwood volleyball and badminton courts, large carpeted infield exercise area, variable resistance equipment, fully appointed locker and changing rooms, clinical assessment area and laboratories and a comprehensive sports medicine section.

With new facilities came the opportunity to add a second major dimension to the program. Because we believed that regular exercise is an important ingredient in preventive cardiology, we designed a second fitness training program for individuals who displayed no clinical evidence of coronary artery disease. This program, called Pre-Fit, does not require a medical referral but is under general medical direction. At the present time a total of 650 persons are enrolled in Reh-Fit and 750 in Pre-Fit.

All participants in Reh-Fit, the more closely supervised program, must be referred by their personal physicians. The individual then undergoes a thorough medical evaluation including history, physical examination, 12 lead EKG, spirometry, fasting blood sugar, serum lipids, CBC, percentage body fat estimation by skin caliper method and graded exercise stress testing utilizing a modified Balke technique. This is supplemented by direct measurement of  $O_2$  consumption. This evaluation is





Table one

	September 19, 1979	May 8, 1979
Serum Lipids	378 mgm%	486 mgm%
Triglycerides	237 mgm%	217mgm%
Total cholesterol	87mgm%	33mgm%
HDL cholesterol	92mgm%	107mgm%
LDL cholesterol	102 mgm%	155 mgm%
Fasting Blood Sugar	21.5%	30%
Body Fat	97 kg.	107.8 kg.
Weight	132/90	145/100
Blood Pressure	7.42mins.	4.52 mins.
Stress Test	11.0mets	8.2 mets

A met represents the measurement of the normal resting oxygen uptake i.e. 3.5 ml/kg/min. At a given workload the multiple of the oxygen cost of rest or number of METS can be directly measured or estimated and is a useful way to characterize work done.

repeated four months after the client starts the program and each year after. Following initial assessment, the client is placed in an introductory exercise class conducted by physical education staff; as he progresses in capability and understanding of the basic principles and becomes more independent, he moves to an intermediate and then senior class. In most instances, clients are free to exercise on their own after several months in the program. Each client exercises three times a week, each session lasting approximately one hour. The emphasis is on aerobic training, that is, exercise involving large muscle groups designed to produce a cardiovascular training effect. Fast walking, jogging, or running according to ability and supplemented by certain upper body exercises are the major components. Some stretching and calisthenics are included and we also emphasize cardiovascular risk factor modification through avoidance of smoking, diet control, hypertension monitoring and management of undue emotional stress.

The Reh-Fit health care team includes a medical director, nurse coordinator, part time physicians, physiotherapist, nutritionist, laboratory technicians and physical educators. The Sports Injury clinic, which is housed in the Reh-Fit building is available for the care of those requiring musculoskeletal assessment and/or treatment.

As nurse coordinator I serve several functions in the Reh-Fit program but the most important involves acting as the main contact point for the participants. In consultation with the physician I plan their individual programs, monitor their progress and maintain liaison between the clients, the various members of the program staff and their referring physician. When necessary I refer

individuals to diabetic, hypertension and lipid clinics at a nearby teaching hospital. During every phase of the program I act as patient counselor, advisor and educator on a wide range of issues: from explaining basic concepts of aerobic training to actions and side effects of medications; from discussing and exploring family relationships to helping someone cope with news that bypass surgery is indicated.

The following case history exemplifies the often remarkable results which can be achieved in the Reh-Fit program. Jim Redmond, an obese 35 year old man with hypertension, coronary artery disease, high blood sugar and hyperlipidemia was hostile, resentful and embittered. He drank and smoked heavily and at the insistence of his family physician grudgingly agreed to enroll in the program. Within five months of enrolling, his serum triglycerides, blood sugars, body fat, weight and blood pressure were all significantly reduced and his exercise tolerance was significantly increased (See Table one). Although total cholesterol was slightly elevated the marked increase in high density lipoproteins indicate clear improvement in lipid risk factors. Despite his initial lack of motivation, he soon began to see and feel changes, his self image and sense of well-being improved and he reduced his alcohol consumption and managed to stop smoking.

Jim Redmond is one of the many examples of successful rehabilitation we have observed in the Reh-Fit program. The rate of recidivism on the whole is extremely low, participants appear to be able to achieve major and continuing lifestyle modifications. While the reasons for this are not fully understood we believe that group participation, the multi disciplinary approach and the

## Modified Balke Technique, as used in Stress Testing

*Treadmill speed is fixed at 5.4 kmph and the grade increased 2 per cent each minute until a symptom or fatigue — limited end point is reached, providing that an arrhythmic or an abnormal blood pressure response does not occur first. When marked disability is anticipated, lower speed and if necessary 1 per cent grade increments are used. This approach, using small load increments and brief test stages, is, in our view, the safest and most precise means of measuring exercise tolerance in disabled people. At the same time it is efficient for stress testing those with normal exercise tolerance.*

commitment, dedication and caring attitude of staff members are all important positive factors. ♡

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# What's the score on sports and eye injuries?



Susan Moses

More Canadians are becoming active in sports; some of them suffer the needless trauma of a serious eye injury. Here's a review of the types of injury that can result, treatment and what to look for in protective equipment.

Squash, racquetball, handball, hockey, lacrosse, tennis, badminton and skiing — what do all these popular Canadian sports activities have in common? They often result in eye injuries. Most people are not aware of their susceptibility to eye trauma, nor are they familiar with the use of protective equipment which can prevent sports-related injuries.

There are several types of eye injuries, some more common than others, which will be described along with the appropriate nursing care following a brief review of the internal structure of the eye.

## Physiology

The *cornea* is the transparent anterior part of the *sclera*, which is the white non-transparent fibrous material covering the eye, except at the back where the optic nerve enters. The cornea serves as the main refracting medium for the eye, and is completely avascular. There are five distinct layers in the cornea; the epithelium layer has more pain nerve fibres than any other part of the eye.

The iris is the colored doughnut-shaped structure surrounding the pupil; a muscle structure, it serves as a sphincter and a dilator, adjusting the pupil according to light conditions. The *crystalline lens* consists of transparent fibres surrounded by a strong elastic capsule, and is suspended directly behind the pupil by zonules which attach it to the ciliary body. The contracting and relaxing action of the ciliary body allows the lens to accommodate to light rays and focus them on the retina.

The *ciliary body* encircles the eye behind the iris, and has several functions: the circular layer assists the lens in accommodation, while the longitudinal layer opens the trabecular spaces allowing aqueous fluid to leave the eye. The *ciliary process* produces the aqueous fluid which fills the anterior and posterior chambers.

The *choroid* is a richly-vascularized layer situated between sclera and retina; the *retina* itself is a very complex network of nerve cells and fibres and is perhaps the most essential part of the eye. Images are received in the retina and transmitted via the optic nerve to the brain where all the visual information is "decoded" and assembled to give one image.

The *vitreous* is a transparent viscous fluid behind the lens which helps give form to the eye and support to the retina; it is relatively inert and formed only during eye growth — if lost it can never be regenerated. The *aqueous humour* flows between two chambers, anteriorly between the iris and cornea, and posteriorly between the lens and the iris.

Essentially a nutritive solution that bathes and feeds the lens, it flows through the pupil into the anterior chamber and then out through the trabecular spaces. The *trabecular spaces* are like a fine sieve, and serve to give a certain resistance to the outflow of aqueous fluid, maintaining intraocular pressure at about 15 to 25 mm Hg.

The *conjunctiva* is the mucous membrane covering the exposed part of the eye and the inner surface of the eyelids. Tears are produced by the lacrimal glands in the upper outer part of the orbit, and cleanse and moisten the cornea, after which they drain off into the lacrimal sac through small ducts in the inner canthus.

The eye itself is enclosed in a bony orbit within the skull, surrounded by fat and fibrous tissue; six muscles outside the eyeball, inserted into the sclera allow for up-down, side to side and diagonal movement.

## Games people play

As Canadians become more aware of the need for personal fitness and exercise, the trend is to participate in active sports or games that are both fun and healthful. Some games are more competitive than others, requiring a greater degree of body contact, or of mind-body coordination. Basically, most injuries are caused by either a blow to the face or eyeball, or by cuts and lacerations across the front of the eye.

Squash is one such sport activity in which serious eye injury can result: because the game is played in an enclosed area with a small hard ball bouncing off any one of six different walls, there is a significant potential hazard. The ball itself is a high-velocity missile, while the racquets too can cause injury. Players need to be alert and attentive at all times, and warm-up with more than one ball in play is not advisable. In squash protective goggles are highly recommended, especially for people who wear glasses and are more likely to incur permanent damage when the glass shatters and is projected into the eye.

Hockey and lacrosse are two fast-moving games which require aggressive action, body contact and the use of sticks and a hard object, the puck. Injuries have decreased due to the use of face masks, but they still occur, the majority being caused by sticks. Most hockey injuries can be prevented by the use of protective equipment.

Unlike squash, tennis and badminton are played in an open area, with opponents on opposite sides of a net and so injuries are less likely to be as severe. Racquets in both sports are potentially dangerous, as is the tennis ball.



Skiing poses a different sort of danger: skiers should be constantly aware of the ability of those skiing around them, and avoid people who are apt to lose control or who are trying out a hill which is beyond their capabilities. A wildly flailing pole can cause serious damage, as can a fall onto a pole or other hard object.

Skidooing too can be hazardous: riders who wear helmets without a visor can brush past tree branches at high speed, causing injury to their eyes.

### Injuries

Ocular trauma resulting from sports activities may be divided into two categories: impact or contusion injuries, and lacerations or abrasions. (There are, of course, other forms of general ocular trauma, such as exposure to corrosive solutions etc.) In reading the various types of injuries one must keep in mind the existence of protective equipment available which can absorb the impact of most objects and save the eye from punishment. Goggles used for racquet sports are virtually indestructible; ordinary eyeglasses are not meant to withstand much pressure, and consequently they may break or cause brow laceration. Contact lenses are no better: they just transmit impact directly onto the eye and occasionally shatter. The injuries listed below apply to the unprotected eye.

**HypHEMA.** Frank bleeding into the anterior chamber may result from a sudden blow to the eye: the blood does not clot, and there may be a second episode of bleeding 24 to 72 hours later. HypHEMA can lead to secondary glaucoma, traumatic uveitis (inflammation of the choroid, ciliary body and iris), or corneal opacity. There is some controversy about treatment, but generally bedrest is prescribed for up to a week. Healing is promoted by having the patient remain quiet and in an upright position—gravity aids re-absorption of the blood in the constant changing of aqueous. Both eyes may be patched to decrease stimulation; topical corticosteroids may be applied to treat or prevent uveitis.

**Secondary glaucoma.** This complication of hypHEMA is the result of tears or lacerations in the iris and ciliary body with subsequent hemorrhage into the anterior chamber. This causes an increase in intraocular pressure which may be treated with Diamox® (usually 250 mg p.o. q.i.d.) which decreases the production of aqueous fluid. If the

# General eye care

- Loose foreign bodies can be removed from the eye by dabbing with clean gauze; otherwise, flush out with water moving from inner canthus outward. Imbedded material should be removed by an ophthalmologist.
- Chemicals splashed in the eye need to be diluted immediately to prevent permanent damage; wash thoroughly with running water before heading to emergency.
- **NEVER** apply pressure to the eyeball to stop bleeding. Go to emergency department immediately.
- Persistent pain, redness, swelling, or blurred vision may be signs of serious problems — go to an ophthalmologist as soon as possible. In the case of trauma, always assume there may be more than a simple 'black eye' when bruising of the eyelids is present.
- Flashing lights, floaters or a curtain across the field of vision may be signs of retinal detachment — seek medical attention.
- People with family histories of diabetes or glaucoma should have yearly eye examinations.
- Promote the use of protective eye gear in sports activities and if required in the workplace. Look for:
  - Goggles should be clear hardened plastic or, if metal, covered with rubber. They should project over the brow and cheekbone so the frame takes all the force of a blow, not the eye.
  - For those who wear glasses, nylon sports frames with plastic lenses are available.

anterior chamber fills completely with blood causing a persistent increase in the intraocular pressure — the trabecular spaces will be blocked — there will be progressive staining of the cornea leading to permanent opacity and visual impairment. The hypHEMA may have to be evacuated surgically, in which case I.V. mannitol may be given pre-operatively to decrease the intraocular pressure.

**Blowout or orbital fracture.** In this type of injury, which results from a blow to the eye, the eye is pushed against one of the orbital walls, usually the orbital floor; the muscle which allows the eye to look upward becomes entrapped. The maxilla bone may or may not be fractured in this injury; if so, lowering of the eyeball may result, causing the patient to complain of diplopia (double vision). Surgery is required only if there has been muscle prolapse, otherwise the patient is on bedrest. Blowout fractures are seen less frequently than hypHEMA.



**Retinal tears and detachment.** Again the result of a severe blow or trauma to the eye, retinal tears or detachment can cause loss of vision if left untreated. There may be accompanying vitreous hemorrhage which means that there is bleeding from the retinal tears into the vitreous fluid. Continued hemorrhaging will decrease visual acuity and treatment may involve vitrectomy, a surgical procedure to remove the blood and replace vitreous fluid with an isotonic solution. In the case of detachment, strict bedrest is prescribed both to stop and to settle hemorrhage. If a tear is present in the superotemporal or superonasal area of the eye, the patient must remain flat to prevent gravitational pull from aggravating the situation. Surgical treatment for retinal detachment is called a scleral buckle in which an implant or encircling element may be used to push the sclera toward the retina. Diathermy may also be used — this is a form of electro-cautery which causes scar tissue to form to which retinal layers adhere. Laser photocoagulation seals off areas around retinal tears and stops hemorrhage.

In addition to the contusion injuries described, injuries to the cornea, abrasions and lacerations may also occur.

**Corneal abrasion** involves removal of epithelial cells when an object is scraped across the cornea. The chief danger here is infection and treatment includes the application of topical antibiotics. An eye patch is used to lessen discomfort and to promote healing by lessening eyelid movement over the affected area.

**Corneal laceration** may result when a contact lens or piece of glass enters the eye and a laceration deep enough to cause leakage of aqueous fluid will result in prolapse of the iris. This seals off the wound but closes off the anterior chamber and means secondary glaucoma may result. Surgery to reform the anterior chamber and prevent permanent adherence of the iris to the cornea is necessary along with removal of the prolapsed portion of the iris. Air or isotonic saline may be injected into the anterior chamber to help reform the chamber; the air is gradually absorbed and replaced with aqueous fluid.

It seems obvious that with protection available in the form of sport or safety goggles, these serious injuries should not be happening. Nurses should inform people of the risks involved to the eye in certain sports and warn of the consequences of leaving eyes unprotected. Before we can start 'spreading the word' however, we should see that we set an example when we take part in our own favorite sports.

Equipped with proper gear and adequate knowledge of safety, we can continue to enjoy the trend in Canada toward more healthy lifestyles: eyesight is not something to be taken for granted! 4

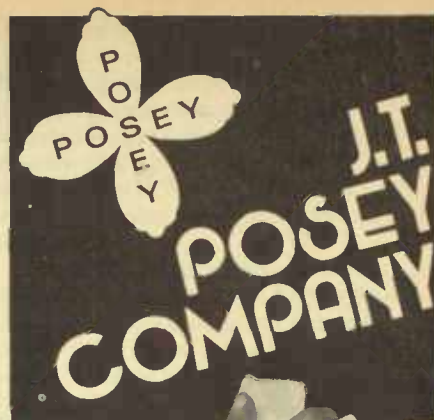
**Susan Moses, RN**, is a graduate of the Vancouver General Hospital School of Nursing, and before moving to Kitimat B.C. worked as a staff nurse at VGH in the ophthalmology service.

The author wishes to thank **M. Carmichael RN** and **M. Bickford** as well as **Dr. J.S.F. Richards** for their assistance with this article.

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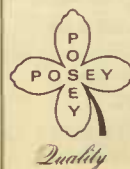
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that uses proven advertising techniques  
to sell health to the consumer.*



# The Body Shop

## Marketing a Healthy Lifestyle

*Anne Esler McMurray*

As part of Healthy Lifestyle, a pilot program started by the Health Commission of New South Wales in Australia, a retail outlet for health has been established in a busy downtown shopping arcade, in the small town of Lismore. This "body shop" has created a showcase for healthy lifestyles and is a focal point for people who can be influenced by advertising messages.

The project itself is an adapted version of the Stanford California three-town model, and it is intended that the effects on identified health risk behavior be compared with a second, or control, town. (A third town will be exposed to the media campaign, but will have no group intervention.) To do this the Commission had to assume two things: first, that the major cause of health problems in Australia are lifestyle or behavior-based and second, that behavior has to be modified on a wide scale using techniques of the mass media, along with provision of self-help material, and intensive group intervention.

Lismore is a town in New South Wales on the east coast of Australia, population 29,000, which combines the youthful activity of a college town with the sleepy conservatism of a rural dairy farming community. The major health problems of the North Coast area and related risk factors were identified: heart and circulatory disease, carcinoma, hypertension and/or stress, and accidents. The principal risk factors associated with these ailments are

smoking, poor diet (leading to hypercholesterolemia), lack of exercise, obesity and drug and alcohol abuse.

Healthy Lifestyle is aimed at active and vigorous re-education of the public through the use of current accepted advertising techniques; health was to be treated as a product which must be sold to the health consumer. The program is, in effect, marketing health. The hope was that people would change their idea of health care from the medical cure-based model to that of preventive health care and the promotion of good health.

The prime targets of the program were not to be those who were already ill, but people who might be converted to using healthier modes of living. The campaign started with the super-healthy ideal and intended to pull people toward realizing this goal for themselves.

### **Setting the stage**

As a community health nurse, I was actively involved in devising, organizing and implementing the Anti-Hypertension Program within the framework of the Healthy Lifestyle project.

At the time of my inclusion in the team, Healthy Lifestyle had already established its place in the community via the media. One of the key figures in this success has been our media coordinator who had already established a reputation in ground level media operation and who could "speak the language". Our Anti-Hypertension Program was therefore planned in and

around tried and proven marketing methods: using the media as a vehicle for information we would treat the desired behavioral change like a product and saturate the newspapers, radio and television with our message as would any other advertiser.

After much discussion a slogan emerged — "Down With High Blood Pressure", from an article title in the *Medical Journal of Australia*<sup>1</sup> which was considered to express the sentiment appropriate to our purposes. A proposal was then submitted to the Health Commission outlining the format of the program; an important feature was "Down With High Blood Pressure" week which would inaugurate proceedings. During this week, screening would be carried out in our body shop, and all community members were invited to have their blood pressure taken. Following this, blood pressure screening would be offered at the shop one day a week, the objective being to screen as many community members as possible in the weeks to follow.

In preparation for "Down With High Blood Pressure" week an all-out media campaign was launched; radio interviews were conducted, a newspaper feature was printed, containing factual information on hypertension and radio commercials were made in which I invited "all of you out there" to come downtown to have blood pressure checks, followed by a 30 second 'sell' on how easy it was to eliminate any worries about hypertension by having a reading



taken. We found that the radio and T.V. afforded much room for creativity and over the next few months we altered the commercials, constantly updating them and trying new approaches.

I felt it necessary too to have a personal visit with each of the family practitioners in the area; preventive health care, no matter how it is promoted, is really what nurses have been doing all along with the technical guidance of the medical profession, and so I thought the cooperation of the doctors would be crucial to the success of our program.

An introductory letter was sent to each, outlining aims and aspirations of the program and ending with the thought that I would appreciate a personal visit; I followed up in one week with a telephone call and got an appointment with each practitioner in town. Meeting the doctors was quite a pleasant experience — most were anxious to discuss the healthy lifestyle concept, and they had many positive comments.

As screening for high blood pressure was to be done simultaneously with education on hypertension, the physicians were also given a description of the proposed classes dealing with hypertension (the group intervention aspect). Modelled on a health education research study conducted in Perth, we would be conducting a course entitled "Living With High Blood Pressure".<sup>2</sup> This consisted of four 90 minute sessions giving facts about hypertension; its management, practice in simple relaxation techniques and overcoming stress, advice on exercise, diet and weight control and group discussion of problem areas, such as patient compliance. Copies of the proposed course content were offered to the doctors in the hope of encouraging them to refer detected hypertensives to the program, and to become involved themselves.

On the whole, the doctors were happy that a community agency was educating hypertensive patients in aspects of control as this was an area they found difficult to handle themselves due to time constraints. Each physician wanted to know the specific details of our program: what criteria were to be used in the screening program, what kind of self-help material was going to be distributed? What demands would be placed on the patients, and would the program be flexible? Information was given to each, and written materials sent to all those who requested it.

An avenue of communication was established between myself and the medical community of Lismore that I found most gratifying in the months to come; comments and suggestions that came from the doctors I had met personally were instrumental in updating

and re-directing the program. One doctor said that he thought the fact that patients were getting information from another source served to reinforce what he had been trying to tell them all along.

The next step was to package our self-help information into a Blood Pressure Kit. The kits were composed of literature with hints on ways to alter lifestyle, advertisements for our classes and a questionnaire to aid in the patient's self-evaluation. Developing the kit was a cooperative effort that involved all team members; we came up with a Relax Kit with a relaxation record, information on how to reduce stress and notices about relaxation classes. The Get Fit Kit followed, as did a Weight Control Kit and a Quit Smoking Kit. There was some overlapping information, naturally, but the basic idea was to give the relevant information in each package.

Timing of the kit distribution was regarded as being crucial to success; individuals seemed more highly motivated to absorb information at the actual time of detection. At no time were the kits marketed as 'cures' or treatments, but they were regarded rather as the first step to an individual's assuming responsibility for his own health. By charging a nominal fee (20 cents) we felt we might increase the buyer's level of commitment to reading and using the kit.

There is a large display of kits in the Body Shop and in the future we plan to set up other displays in doctors' offices and perhaps pharmacies. A further development is the pre-printed prescription pad which the physician can use to check off any number of Healthy Lifestyle programs he feels may supplement his patient's medical treatment. These pads have a two-fold benefit in that they increase the physicians' involvement in lifestyle counseling, and they encourage the patients to take responsibility for improving their health.

### Nursing and health promotion

As well as dispensing the information kits, liaising with doctors, and helping to advertise the program, the function of the nurse in our Down With High Blood Pressure program specifically included taking clinical information from the health consumers, or patients, and taking blood pressures.

Each person sat with me at a desk and together we filled out a history form, noting basic background information such as age and sex, and whether or not there had been a history of hypertension in the past. A set of questions designed to determine the presence of lifestyle risk factors is asked; these cover obesity, irregular meal patterns, exercise routines if any, smoking or drinking habits and — if the individual is a known hypertensive — what his medication regime is, and how well he has complied with it.

The history-taking session usually takes about five minutes, after which the person is sufficiently quiet and relaxed to have his blood pressure measured.

Actually, most people who come into the Body Shop have to wait fifteen to twenty minutes before being seen, but this time is not wasted. The waiting area is dominated by a video-tape machine on which tapes on fitness, relaxation and smoking are run. All the tapes are realistic, portraying healthy lifestyles as attainable goals. One film in particular, produced locally, shows an "average bloke" who progresses from spending time in smoke-filled pubs to playing on the rugby field.

Several days we have had salt-free cooking demonstrations for those waiting to have their blood pressures taken. With the help of the team nutritionist, recipes were printed for distribution; each contains a salt-free recipe, hints on herbs or spices that can be substituted for salt to enhance flavor, and a cooking tip.

People who have a blood pressure of 140/90 or below are given a brief







explanation of what blood pressure is along with a pamphlet produced by the Australian Heart Foundation. Those whose pressures are above this level are given the same physiological explanation along with a mention of how stress can affect a reading, and they are asked to return in two weeks for a re-check. If on the return visit, their blood pressure is still above 140/90 they are referred to their personal physician for diagnosis. A few cases have presented in which readings of 200/100 were found — these people were asked to see their doctors without a re-check or further delay.

#### Findings

To date, in the Lismore Body Shop we have found 55 people who were previously undetected hypertensives and who were subsequently positively diagnosed by their doctors. This figure represents 4 per cent of the number of people (just under 2000 people) screened in the first four months of the program. It is interesting to note that there is no correlation proven in our findings between designated risk factors and hypertension, but this is quite likely a function of the type of people who are volunteering for the screening program.

One nursing study<sup>3</sup> reported that shopping center screening programs scanned less than one-tenth of the local adult population, and our experience has corroborated these findings. Therefore, we are now planning to take the program to the workplace and we are hoping for some interesting results in treating Down With High Blood Pressure as an occupational health project.

The ideal, or the goal we give our clients to strive for, is to metamorphose completely the stereotyped swashbuckling Aussie who is overweight, smokes heavily and has a prodigious capacity for alcohol, into a

1980's model of glowing good health and well-being. I am not convinced that this can occur quickly on a large scale, but we hope for some transformations.

The Federal government and the Cancer Council of New South Wales has funded a panel of research experts to study the effects of Healthy Lifestyle, and the program will be evaluated in the spring of 1980. But the team involved in the Body Shop has noticed a few changes already. By using cooperative media, maintaining a high profile, delivering information and working with existing community resources we hope we have affected attitudes about lifestyle.

We have seen some developments: a newspaper column devoted to fitness and lifestyle now appears regularly, soccer, cricket and other sport teams are now wearing T-shirts that say "Be Nice to Your Body", and cars are seen on the main street of town with bumper stickers advising "Kiss a Non-Smoker — Taste the Difference". Not one local merchant is unaware of Healthy Lifestyle, and while health food shops are springing up, butchers are bothered by requests to 'trim the meat'. The local brewery has produced a low-alcohol beer, salt substitutes and vegetable steamer baskets are in heavy demand, and when I see the number of joggers around town I feel I am back in Saskatoon!

We move into the 1980's on a wave of change from treatment to prevention, from the institution to the community. Belloc and Breslow in studying adult Americans have demonstrated the relationship between 'good' lifestyles and good health — regular sleep, meals and physical activity, moderate drinking and smoking — and conversely the negative relationship to 'poor' lifestyles.<sup>4</sup> The time to broaden health horizons is now. Perhaps numerous avenues exist out there to explore in the way of support

systems for delivering health care: marketing health as a product is only one. Whatever the system, nurses in all countries must focus on a lifestyle for the future. We have conquered many diseases caused by heredity and the environment — now it is on to those which are man-made. ♡

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*Anne Esler McMurray is a graduate of the St. Joseph's School of Nursing in Guelph, Ontario, and will be returning to Canada in 1980 to complete her studies toward a BA in Psychology at the University of Manitoba. Her nursing experience includes occupational health nursing in Manitoba and Saskatchewan, and she has had an article published on an occupational health research project she conducted. She says that her interest in fitness was influenced by her attendance at the VON sponsored fitness camp at Lake Couchiching in 1978, and by the ideas on lifestyle changes as presented by Mall Peepre and organizers of Fitness and Amateur Sport, Ottawa.*



# Tomorrow's nurses shape up for a healthy future

Kendy Bentley Bonnie Friesen

Twice a week, at about four-thirty in the afternoon, huffing, puffing, grunts and groans, mixed in with a good deal of laughter, can be heard emanating from the gymnasium of Foothills Hospital School of Nursing in Calgary as approximately 60 students and several courageous instructors participate in their own special fitness program.

Development of the program is directly attributable to the enthusiasm generated by nursing instructor Bonnie Friesen, BScN, on her return from one of the three National Workshops on Fitness and Lifestyle for nurses held at Geneva Park, Ontario in 1977, 1978 and 1979.

Bonnie was instrumental in forming a committee to develop a curriculum component in this area and Kendy Bentley, BScN, a nurse and fitness consultant was hired to assist in planning and presentation of the program package.

The program, as it now exists, is in two parts: a compulsory lecture series and voluntary exercise sessions. Students attend a total of ten hours of lectures on topics such as: fitness for the nurse, as a person and as a practitioner; aerobics; weight control; dangerous exercises and fitness throughout the family cycle.

The activity sessions are voluntary and include two 45-minute sessions of exercise to music each week. The "fun" aspect of fitness is emphasized, although the activities are vigorous and include exercises for all components of fitness: flexibility, muscular strength and endurance, cardiovascular endurance and weight control.

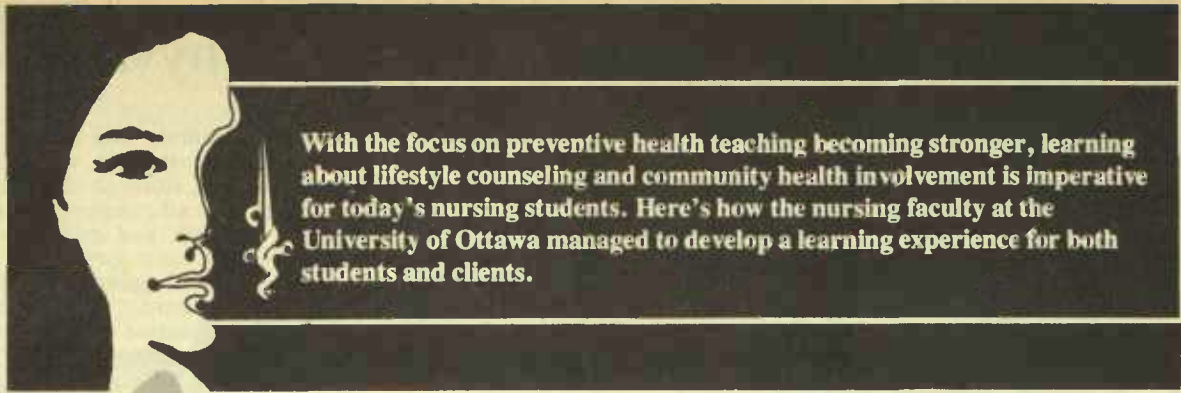
The program is still expanding: a jogging group has been formed and a special fitness bulletin board, "The Health Hoedown", has been set up. The committee continues to work on ideas to improve the program and would enjoy communicating with other schools of nursing which incorporate the concepts of health, lifestyle and fitness into their programs.

For more information, you can write to:

Bonnie Friesen, Nursing Instructor  
Foothills Hospital School of Nursing  
1403 - 29 Street, N.W.  
Calgary, Alberta T2N 2T9. ♡







With the focus on preventive health teaching becoming stronger, learning about lifestyle counseling and community health involvement is imperative for today's nursing students. Here's how the nursing faculty at the University of Ottawa managed to develop a learning experience for both students and clients.

Save your own life

## A Community Health Teaching Project for Students

*Marion Logan*

As the teacher responsible for organizing the community nursing clinical experience for third year baccalaureate students, I was interested in developing a useful experience for the students, an experience that would involve the co-operation of services within the university community and provide an opportunity for student involvement in group organization and application of the nursing process.

During meetings with the Field Secretary for the Ontario Division of the Canadian Cancer Society, it became obvious to me that clinics on self breast examination are of major importance in any efforts to detect and treat breast cancer during early stages of the disease. When I investigated, I found that a clinic on this topic had never been presented at the university; a review of the size and age range of the female population of the community confirmed that the subject would be appropriate.

The nursing students developed a plan with teacher assistance that focused on two objectives: first, to identify and obtain the assistance of key areas or resources within the university community; second, to identify and delegate essential tasks into four committees.

The areas identified for contact were the Women's Centre, Health Service, the Student's Federation, the personnel department, supply and services department, communication department and the local branch of the Canadian Cancer Society.

To co-ordinate and delegate responsibilities we formed four main committees — advertising, volunteer, audiovisual and equipment. A student co-ordinator was elected for each committee and students volunteered to participate in at least one of four committees. Each committee developed a plan of action and met as often as required to implement the plan. Teacher contact was maintained with each group and assistance was provided when needed.

### *The Advertising Committee*

The principal focus of this group was obviously directed at publicizing the event. As the topic of the clinic was of interest to all females on campus, the advertising was directed broadly at students, support staff and academic personnel. The co-ordinator of the Women's Centre was actively involved with this particular committee. Activities included a successful application for funds from the students' federation,



editing and translating material received from the Cancer Society so that it was available in both English and French, and the design of a poster. Public service announcements were also written and distributed to local press and radio, and the poster was published in the campus newspapers. The personnel department distributed a letter about the clinic to all female support staff members at the university and each female professor or teacher received a 'flyer'. In addition, the advertising committee organized and assisted in the running of information booths open the week prior to the clinic day, and arranged for all employees to receive sufficient time off work to attend the clinic.

#### *Volunteer Committee*

The job of this committee was to identify the areas at the clinic that would require volunteers — registration, pamphlet review and demonstration. The responsibilities included determining the number and rotation of volunteers needed, recruitment and training, and general co-ordination of the activities at all three stations on the clinic day.

#### *Audiovisual Committee*

With the assistance of the communications department, this committee focused its efforts on the use of audiovisual aids for the clinic. This involved the selection of appropriate films for showing — *Vos Seins, il faut y voir* and *Something Very Special* — and identifying the needed equipment. After the committee obtained the equipment and trained the volunteers, it supervised the station's activities on clinic day.

#### *Equipment Committee*

The activities of this committee were centered on equipment needed for actual operation of the clinic which required determination of exactly what was needed and where one could obtain it, followed by the delivery, setting up and return.

#### *Clinic Day*

The most accessible and obvious place was the main foyer of the University Centre at the heart of our campus which was where our clinic was held on a Thursday at the end of January from 0900 to 2100 hours. Two stations, "Registration" and "Pamphlet Review" were held right in the foyer while the other two stations, "Films" and "Demonstration" were located in private rooms off the main area.

The room used for demonstration was divided into four private cubicles with a large sitting area adjoined. Next to the sitting area was a table with the demonstration model (Betsy) and another table where clients could fill out an evaluation form.

Each station had two volunteers except the demonstration area which required one volunteer for each private cubicle and table. An effort was made to provide client assistance in either the English or French language, according to the needs of the individual.

Each client attending the clinic was welcomed by a hostess and then directed to the various stations: first to Registration to complete a form and receive a brief explanation of the format of the clinic, then to station two where she received a pamphlet on self examination. At the third station, each client could view a film on breast examination, in either French or English, and finally she could practice what she had learned on the model and on herself in one of the private cubicles we provided.

While the clients were encouraged to visit all the stations, they were free to choose as many as they wished. At the final station they were asked to write brief comments evaluating the usefulness of the clinic, and to tell us how they had learned about its existence. It was estimated that the time required to complete all the stages of the clinic visit was about twenty minutes.

#### *Client comments*

The comments we received from our clients were very helpful. They included:

- the model was greatly appreciated; attenders felt that practicing on a model first helped them feel more comfortable before proceeding to self examination.
- the majority commented that the use of the films was excellent.
- many women felt encouraged in the belief that they were responsible for maintenance of their own health.
- more French services should be available, specifically French-speaking nurses and literature.
- the variety of teaching methods was appreciated.
- the most successful means of publicizing the clinic seemed to be by letter or personal communication.

- the clinic, some clients felt, should be repeated every six months or annually.
- clinics on other health topics should be encouraged.

#### *Student evaluation*

As part of the assignment, students too were asked to comment on the success of their community health project. Among their comments were the following:

- January was a poor month for a clinic due to poor weather and the lack of time after Christmas holidays for proper advertising.
- more cubicles were needed in the demonstration area.
- the need for privacy in the demonstration area cannot be overestimated.
- clients seemed to need extra encouragement to attend the demonstration area but once they did they felt it was the most beneficial.
- more spacing was needed between French and English tables as voices carried and were distracting.

#### *Looking back*

A discussion session was held after the clinic and all of the students who had participated agreed that they had gained a tremendous amount of knowledge from this learning experience. They felt that key areas within the university had been more than willing to assist and had actually helped considerably with the clinic. They felt there had been the added bonus in that many areas of the university community were now more aware of activities in the School of Nursing. ♡

*Marion S. Logan is assistant professor at the School of Nursing, Faculty of Health Sciences, University of Ottawa, where she obtained her BScN in Public Health and her master's degree in education. Her nursing experience in the past includes work as a hospital staff nurse, public health nurse and nursing educator at both the diploma and baccalaureate levels.*

*The author hopes that in describing the project that was used at the University of Ottawa other educators will be assisted in planning health teaching clinics. She states that the effort is certainly worthwhile; although the planning, implementing and evaluating of such a clinic takes a considerable amount of time and energy, she feels it is a most rewarding experience for both the student organizers and their clients.*



# Introducing New they stay twice

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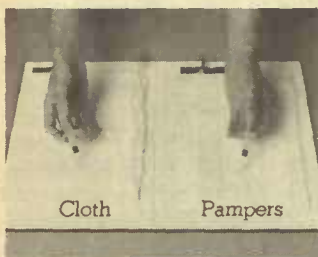
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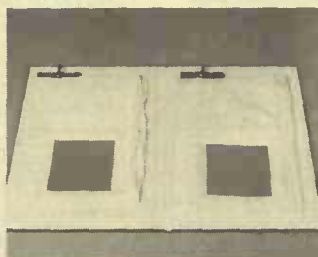
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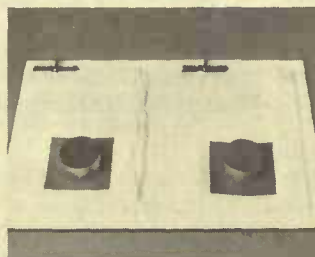
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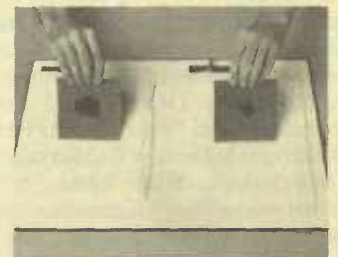
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# audiovisual

## The Fit-Kit: The Canadian Home Fitness Program.

The Fit-Kit contains information for Canadians to develop and maintain an exercise program suited to their individual needs. The program consists of "Fit-tips", which explain with pictures eleven different stretching and warm-up

exercises, a "Walk/Run Distance Calculator" which helps the individual determine how far he/she should walk or run in 15 minutes at least three times a week to maintain or improve personal fitness levels and a booklet demonstrating the need for minimum aerobic fitness including a list of pleasant and fun activities which build up endurance. The

information on the Exercise Program is sound and accurate.

"The Canadian Home Fitness Test" section of the kit includes a progress chart, an evaluation chart and a record with music tempos which differ for most sex and age groups. The test is administered by the "step-test" and the fitness level is measured by the pulse rate at the end of each three minute stepping exercise.

A word of caution here; all steps that I measured were only 7" high as opposed to the 8" or 20.3 cm height required by the test. This can alter results significantly. Also research has shown that the test is not a good indicator of cardiorespiratory fitness, due to errors in stepping rates and palpated heart rates.

The Fit-Kit could be useful as a motivational and educational tool to stimulate interest in fitness but caution should be used lest the test lead the person to believe he is more fit than he is. Reviewed by Marilyn S. Riley, Associate Professor, Dalhousie University, School of Nursing and President, Registered Nurses Association of Nova Scotia.

## Nurses: Try Canada's Northland This Summer

## Infirmières: Découvrez les Terres Septentrionales du Canada cet été.



Join the team providing health care to the residents of the Northwest Territories. Medical Services, Northwest Territories Region will be offering a number of term positions for qualified and experienced nurses.

Positions are available at nursing stations, health centres and hospitals for the period, May through September.

Knowledge of the English language is essential.

For more information write to: Nursing Advisor, Human Resource Planning, Medical Services Branch, Health and Welfare Canada, Room 1972, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario K1A 0L3

NOTE: Permanent positions are also available.

Open to both men and women



Joignez-vous à l'équipe médicale qui soigne les habitants des Territoires du Nord-Ouest. La direction des Services médicaux, région des Territoires du Nord-Ouest, offre des postes d'infirmières diplômées, pour une période déterminée.

Les postes offerts se trouvent dans des postes de soins infirmiers, des centres sanitaires ou des hôpitaux; la période de travail va de mai à septembre.

La connaissance de l'anglais est indispensable.

Pour de plus amples renseignements, prière d'écrire à l'adresse suivante: Conseillère en soins infirmiers, planification des ressources humaines Direction générale des services médicaux Santé et Bien-être social Canada Pièce 1972, Immeuble Jeanne Mance Parc Tunney Ottawa, Ontario K1A 0L3

REMARQUE Des postes permanents sont également offerts.

Appel de candidatures mixtes



Fit to sing by Martin Collis. (Long-playing record) Phactory Phresh Phitness Corp., 2415 Alpine Cres., Victoria, B.C. V8N 4B5.

Approximate price: \$7.98.

Fit to sing gives a unique fitness and lifestyle message. Martin Collis, a well known Canadian physical education expert, has put together a mixture of songs and commentary on a number of different topics including diets, risk factors in heart disease, exercise, sporting competitions, exercise equipment and donations to the Heart Fund. The music ranges from folk to country to rock, and Martin Collis' vocals are backed by some excellent musical arrangements. Fit to sing would be useful to anyone giving talks on fitness and lifestyle. The variety of the songs would allow selection of the most appropriate message for each audience. As well as being a useful teaching aide, Fit to sing would be an enjoyable addition to a record collection. Reviewed by Ruth McKenzie, RN, MN, Research Assistant, VON for Canada, Ottawa, Ontario.



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comparable to most Canadian facilities. And, when my shift was over, I went home to an attractive, free, air-conditioned apartment. The travel benefits were tops too. And my salary and year-end bonus were great. All in all, the experience was invaluable. Which is why I'm

talking to other Canadian nurses about it. And some day I'm going back there.”

Dorothy Redden's reactions are typical. And Whittaker, a leader in international health care, is now offering contracts in either Saudi Arabia or Abu Dhabi. If you're a Canadian trained RN with 2-3 years postgraduate experience, call us today on our Toll Free line.

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## Alberta

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**Registered Nurses** required for a 560-bed acute care hospital in Edmonton, Alberta. Positions available in most clinical areas. Candidates must be eligible for registration in Alberta. Current salary rates under review. Apply to: Personnel Department, Edmonton General Hospital, 11111 Jasper Avenue, Edmonton, Alberta T5K 0L4.

**Registered Nurses** required immediately for 36-bed hospital in Northern Alberta. Salary is in accordance with the A.A.R.N. contract, plus northern allowance. Subsidized single staff housing available. Applicants must be eligible for registration with the AARN. Apply to: Personnel Department, Northwestern Health & Social Services, Bag 400, High Level, Alberta T0H 1Z0.

**Wanted — R.N.'s** for 75-bed accredited hospital in northern Alberta. Policies as per A.A.R.N. contract. Apply in writing, including telephone number to: Personnel Department, High Prairie Regional Health Complex, High Prairie, Alberta T0G 1E0.

**Registered Nurses** required in a 68-bed active treatment hospital in northeastern Alberta. Salaries and benefits in accordance with negotiated provincial agreement. Accommodation is available in the Nurse's Residence. Apply in writing to: Director of Nursing, Lac La Biche General Hospital, Box 507, Lac La Biche, Alberta T0A 2C0.

**Required — Full-time and part-time Registered Nurses** to rotate all three shifts in Active Treatment 66-bed Hospital. Apply to: Director of Nursing, Taber General Hospital, Box 939, Taber, Alberta T0K 2G0.

## British Columbia

**Experienced General Duty Graduate Nurses** required for small hospital located N.E. Vancouver Island. Maternity experience preferred. Personnel policies according to RNABC contract. Residence accommodation available \$30 monthly. Apply in writing to: Director of Nursing, St. George's Hospital, Box 223, Alert Bay, British Columbia V0N 1A0.

**Operating Room Head Nurse**—Must be RNABC registered. Must have experience in all O.R. procedures. Salary: according to the RNABC Agreement. Please apply in writing to: Mrs. A. Houghton, Director of Nursing, Fort St. John General Hospital, 9636—100th Avenue, Fort St. John, British Columbia V1J 1Y3.

**General Duty Nurses**—Must be registered with RNABC. Salary according to the RNABC Agreement. Please apply to: Mrs. A. Houghton, R.N., Director of Nursing, Fort St. John General Hospital, 9636—100th Avenue, Fort St. John, British Columbia V1J 1Y3.

## British Columbia

**General Duty Nurse** for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurse's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia, V0H 1H0.

**General duty nurses** required for all clinical areas and O.R. in a 360-bed acute care general hospital. Salary and fringe benefits in accordance with RNABC contract terms. Apply to: The Director of Nursing, Nanaimo Regional General Hospital, Nanaimo, B.C. V9S 2B7.

**Experienced Nurses** (B.C. Registered) required for a newly expanded 463-bed acute, teaching, regional referral hospital located in the Fraser Valley, 20 minutes by freeway from Vancouver, and within easy access of various recreational facilities. Excellent orientation and continuing education programmes. Salary—1979 rates—\$1305.00—\$1542.00 per month. Clinical areas include: Operating Room, Recovery Room, Intensive Care, Coronary Care, Neonatal Intensive Care, Hemodialysis, Acute Medicine, Surgery, Pediatrics, Rehabilitation and Emergency. Apply to: Employment Manager, Royal Columbian Hospital, 330 E. Columbia St., New Westminster, British Columbia, V3L 3W7.

**Experienced Nurses** (eligible for B.C. Registration) required for full-time positions in our modern 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia, V3L 5E8.

**General Duty RN's or Graduate Nurses** for 54-bed Extended Care Unit located six miles from Dawson Creek. Residence accommodation available. Salary and personnel policies according to RNABC. Apply: Director of Nursing, Pouce Coupe Community Hospital, Box 98, Pouce Coupe, British Columbia or call collect (604) 786-5791.

**Registered Nurses** required for permanent fulltime position at a 147-bed fully accredited regional acute care hospital in B.C. Salary at 1979 RNABC rate plus northern living allowance. One year experience preferred. Apply: Director of Nursing, Prince Rupert Regional Hospital, 1305 Summit Avenue, Prince Rupert, British Columbia, V8J 2A6. Telephone (collect) (604) 624-2171 Local 227.

**General Duty Nurses** required by an active 80-bed acute care and 40-bed extended care hospital located in the Cariboo region of B.C.'s central interior. Year-round recreational activities in this fast growing community. Applicants eligible for B.C. registration preferred. Apply in writing to: The Director of Nursing, G.R. Baker Memorial Hospital, 543 Front Street, Quesnel, British Columbia V2J 2K7.

**Registered Nurses** required immediately for permanent full time positions at 10-bed hospital in B.C. Salary at 1978 RNABC rate plus northern living allowance. Recognition of advanced or primary care education. One year experience preferred. Apply: Director of Nursing, Stewart General Hospital, Box 8, Stewart, British Columbia, V0T 1W0. Telephone: (604) 636-2221 Collect.

## British Columbia

**General Duty Nurses** required for an active, 103-bed hospital. Positions available for experienced R.N.'s and recent Graduates in a variety of areas. RNABC Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

**Experienced maternity, I.C.U./C.C.U., and Operating Room General Duty nurses** required for 103-bed accredited hospital in Northern B.C. Must be eligible for B.C. registration. Apply in writing to the: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia, V8G 2W7.

**Registered Nurses** for summer camps for the disabled at Winfield, Squamish and Shawnigan Lake, starting May or June for 3-4 months. Apply Co-ordinator, B.C. Lions Society for Crippled Children, 171 W. 6th Ave., Vancouver, B.C. V5Y 1K5; Telephone (604) 873-1865.

**Registered Nurses** — Full-time and casual relief positions are available at the University of British Columbia, Health Sciences Centre, Extended Care Unit. The 12 hour shift, the problem oriented record charting system, and emphasis on maintaining a normal and reality based clinical environment, and an interprofessional approach to management are some of the features offered by the Extended Care Unit. Interested applicants may enquire by calling 228-6764 or 228-2648. Positions are open to both male and female applicants.

## Manitoba

**Registered nurses** required for a fully accredited 100-bed general hospital and a 72-bed personal care home located in northern Manitoba. Must be eligible for registration in Manitoba. Salary dependent on experience and education. For further information contact: Mrs. Mona Seguin, Personnel Director, St. Anthony's General Hospital, The Pas Health Complex Inc., P.O. Box 240, The Pas, Manitoba R9A 1K4; or phone collect to: 1-204-623-6431, Ext. 179.

**Challenging Career Opportunity for Registered Nurses in Canada's North** — A 100 bed acute care hospital in Northern Manitoba which services Thompson and several small communities in the surrounding area has immediate vacancies in Pediatrics, Medicine/Surgery, Obstetrics and Critical Care. This opportunity will appeal to nurses who want to increase their existing skills or develop new skills through our comprehensive inservice program. Many of our nurses have become experienced in flight nursing. Candidates must be eligible for provincial registration as active practicing members. We offer an excellent range of benefits, including free dental plan, accident, health and group life insurance. Salary range is \$1,078 - \$1,340 per month dependent on qualifications and experience plus a remoteness allowance. Apply in writing or phone: Mr. R.L. Irvine, Director of Personnel, Thompson General Hospital, Thompson, Manitoba, R8N 0R8. Phone: (204) 677-2381.

## Newfoundland

**Director of Nursing** — Applications are invited for the Director of Nursing position at this 135-bed general hospital. The position must be filled by June 1980. The incumbent will be a member of the senior management staff, will report to the Administrator and will be responsible for all activities related to the Nursing Department. The applicant should hold a Bachelor's degree in nursing and have extensive experience in managing a nursing department. Registration, or eligibility for registration, in Newfoundland is essential. Salary: \$18,654 - \$23,807. Applications with resume outlining experience and educational background should be addressed to: The Administrator, Carbonear General Hospital, P.O. Box 20, Carbonear, Newfoundland A0A 1T0.



## New Brunswick

**Faculty members** required with teaching and clinical experience for an integrated undergraduate program. (1) Medical-Surgical Nursing, to work with team who teach seniors in an acute care setting; (2) Maternal and Child Health Nursing, to teach second year students in pediatrics, and third year students in the Nursery; (3) Community Nursing, to teach freshman students in the classroom, with observations in the community in the first term and clinical teaching in geriatrics in the second term. Directing community experiences for second year students. Applicants should be able to qualify for the rank of Assistant or Associate Professor. Master's degree essential. Salary in accordance with qualifications and experience. Apply with curriculum vitae and names of referees to: Dean I. Leckie, Faculty of Nursing, University of New Brunswick, P.O. Box 4400, Fredericton, New Brunswick E3B 5A3.

## Northwest Territories

The Stanton Yellowknife Hospital, a 72-bed accredited, acute care hospital requires registered nurses to work in medical, surgical, pediatric, obstetrical or operating room areas. Excellent orientation and inservice education. Some furnished accommodation available. Apply: Assistant Administrator-Nursing, Stanton Yellowknife Hospital, Box 10, Yellowknife, N.W.T., X1A 2N1.

## Ontario

**Registered Nurse** required immediately — mostly day shift for Home for Mentally Retarded Children. Apply to: Director of Nursing, Lakewood Nursing Home Inc., Box 1830, Huntsville, Ontario P0A 1K0.

**R.N. Grad or R.N.A., 5'6" or over and strong,** without dependents. Non-smoker for 180 lb. handicapped retired executive with stroke. Able to transfer patient to wheelchair; live-in 1/2 year in Toronto, 1/2 year in Miami. Wages \$250.00 to \$300.00 weekly NET plus \$100.00 weekly bonus on most weeks in Miami. Write: M.D.C., 3532 Eglinton Avenue West, Toronto, Ontario M6M 1V6.

## Quebec

**Registered Nurse** required beginning of September 1980 in Co-ed Boarding School in country. Applicant must live in and share duties with another resident nurse. Apartment with maid service provided. Excellent working conditions. Liberal holidays. Applications stating qualifications and experience to: Comptroller, Bishop's College School, Lennoxville, Quebec J1M 1Z8.

**Camp Nurses** required for children's summer camp in beautiful Quebec Laurentians. Mid-June to end of August. Resident M.D. Contact: Mr. Herb Finkelberg, Director of Camp B'Nai B'Rith, 5151 Cote St. Catherine Rd., Suite 203, Montreal, Quebec H3W 1M6, or telephone (514) 735-3669.

**Nurses for Children's Summer Camps in Quebec.** Our member camps are located in the Laurentian Mountains and Eastern Townships, within 100 mile radius of Montreal. All camps are accredited members of the Quebec Camping Association. Apply to: Quebec Camping Association, 2233 Belgrave Avenue, Montreal, Quebec, H4A 2L9, or phone 489-1541.

## Saskatchewan

**General Duty Registered or Graduate Nurses** required for 19-bed Active Hospital in Central Saskatchewan. Salary and fringe benefits as in effect with S.U.N. Contract (1980 under review). Residence accommodation available at nominal costs. Please apply in confidence to: Mrs. Doreen M. Smart, D.O.N., Maidstone Union Hospital, Box 160, Maidstone, Saskatchewan S0M 1M0.

## United States

**Come to the beautiful N.J. seashore!** Burdette Tomlin Memorial Hospital in Cape May Court House, N.J. (10 miles from Wildwood by the Sea) has 6 immediate RN openings on the 11-7 shift in the areas of med/surg, CCU, ICU & OB. Orientation and education will be provided for qualified professionals. Applicants will be required to speak good English; to sign a 2-year contract and pass N.J. State Boards within two testings. Good benefits and salary. Apply in writing and send copies of nursing school grades, high school grades, Canadian license and other pertinent data to: Mrs. T. Karer, Ass't. Admin. - Nursing, Burdette Tomlin Memorial Hospital, Stone Harbor Blvd., Cape May Court House, N.J. 08210.

## United States

**Nurses—RNs—Immediate openings** in California-Florida-Texas-Maryland-Virginia and many other States — if you are experienced or a recent Graduate Nurse we can offer you positions with excellent salaries up to \$16,000 per year plus all benefits. Not only are there no fees to you whatsoever for placing you, but we also provide complete Visa and Licensure assistance at also no cost to you. Write immediately for our application even if there are other areas of the U.S. that you are interested in. We will call you upon receipt of your application in order to arrange for hospital interviews. You can call us collect if you are an RN who is licensed by examination in Canada or a recent graduate from any Canadian School of Nursing. Windsor Nurse Placement Service, P.O. Box 1133, Great Neck, New York 11023, (516) 487-2818.

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Applications are encouraged from both men and women.  
Applications with curriculum vitae should be submitted to:

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**California** — Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, ext. 1680.

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**RN'S** — Our Florida hospitals need you! Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. **No Fees!** Call or write: Medical Recruiters of America, 1211 N. Westshore Blvd., Suite 205, Tampa, Florida 33607 — (813) 872-0202.

**The Best Location in the Nation**—The world-renowned Cleveland Clinic Hospital is a progressive, 1030-bed acute care teaching facility committed to excellence in patient care. **Staff Nurse positions** are currently available in several of our ICU's and 30 departmentalized medical/surgical and specialty divisions. Starting salary range is \$14,789 to \$17,056, plus \$1248/year ICU differential and premium shift differential, comprehensive employee benefits and an individualized 7 week orientation. We will sponsor the appropriate employment visa for qualified applicants. For further information contact: Director-Nurse Recruitment, The Cleveland Clinic Hospital, 9500 Euclid Avenue, Cleveland, Ohio 44106 (4 hours drive from Buffalo, N.Y.); or call collect 216-444-5865.

**Come to Texas** — Baptist Hospital of Southeast Texas is a 400-bed growth oriented organization looking for a few good R.N.'s. We feel that we can offer you the challenge and opportunity to develop and continue your professional growth. We are located in Beaumont, a city of 150,000 with a small town atmosphere but the convenience of the large city. We're 30 minutes from the Gulf of Mexico and surrounded by beautiful trees and inland lakes. Baptist Hospital has a progress salary plan plus a liberal fringe package. We will provide your immigration paperwork cost plus airfare to relocate. For additional information, contact: Personnel Administration, Baptist Hospital of Southeast Texas, Inc., P.O. Drawer 1591, Beaumont, Texas 77704. An affirmative action employer.

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**Nurses — RNs** — A choice of locations with emphasis on the Sunbelt. You must be licensed by examination in Canada. We prepare Visa forms and provide assistance with licensure at no cost to you. Write for a free job market survey Or call collect (713) 789-1550. Marilyn Blaker, Medex, 5805 Richmond, Houston, Texas 77057. All fees employer paid.

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**Electrolysis** — Successful Electrolysis Practice for Sale. 6 months specialized included. Write or phone: Margot Rivard, 1396 St. Catherine Street West, Suite 221, Montreal, Quebec, H3G 1P9. Telephone: (514) 861-1952.

## R.N.'s Required

Applications are invited for full time nurses to work rotating shifts in new 40 bed active treatment hospital. High level of activity in Emergency, Surgery and Obstetrics offers challenge and the benefit of valuable experience for conscientious nurses. Previous experience an asset. Must be registered or eligible for registration in Alberta.

AHA/AARN policies in effect.

Hinton is a modern, progressive, industrial town on the eastern slopes of the Rockies, 50 miles east of Jasper. Population 7,600. Unlimited year round recreational facilities.

Apply with full resume including experience and references to:

Director of Nursing  
Hinton General Hospital  
Box 40  
Hinton, Alberta  
T0E 1B0

## MOUNT ROYAL COLLEGE Post Basic Mental Health Nursing Program for Registered Nurses

A one-year clinical and academic program intended to prepare clinical practitioners in Mental Health Nursing will be offered by Mount Royal College commencing September 1980. This program has been designed to meet university transfer requirements.

Enrollment is limited to 20 students. Applications for the September class close May 15, 1980.

A limited number of bursaries (\$315/mo) plus tuition are available.

Admission Requirements: Current Canadian Registration.

For further information write to:

Marlene Meyers, Director, Post-Basic Mental Health Nursing Program, Allied Health Department, Mount Royal College, 4825 Richard Road S.W., Calgary, Alberta T3E 6K6

## Director of Nursing

A Director of Nursing is required for Slave Lake General Hospital, an accredited 34 bed active treatment hospital 250 kilometres northwest of Edmonton.

Applicants must have an enthusiasm for initiating and following up new ideas, projects and programs with a desire to participate in clinical nursing. The Director of Nursing is also responsible for orientation and in-service education.

The successful applicant should have experience in the administration of a nursing program and possess a B Sc N Degree, but an equivalent combination of formal education and experience will be considered.

Salary negotiable. Position available immediately. Please direct resume to:

B. R. Popp  
Administrator  
Slave Lake General Hospital  
Box 330, Slave Lake, Alberta T0G 2A0

## Director of Nursing Service Required For Macleod Municipal Hospital

Applications are invited immediately for the above position in a 32-bed active treatment hospital situated in South Western Alberta. Present plans are to commence construction of a totally new 42 bed facility in September 1980.

The successful applicant must be eligible for registration with the A.A.R.N. and should have administrative experience and training. B.Sc. Nursing most welcome.

Address all inquiries in writing together with a complete resume to:

Mr. G. Neil McMartin  
Administrator  
Macleod Municipal Hospital  
P.O. Box 520  
Fort Macleod, Alberta  
T0L 0Z0  
Phone (403) 553-4024

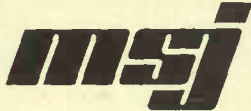


## Intensive Care Nurses

300 bed Accredited general hospital in Vancouver requires full-time R.N.s for 4 bed I.C.U. Candidates should be eligible for registration with the RNABC. Previous I.C.U. experience required.

Please apply in writing to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
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## Summer Employment

### Registered Nurses

Nursing opportunities will be available for a 3 or 4 month period during the months of May, June, July, August 1980. Nurses will provide primary nursing care, be able to exercise clinical judgement and participate in a patient-family oriented program in our modern 300 bed teaching extended care unit. Interested nurses, who are eligible for registration in British Columbia should write to:

Hospital Employment Officer  
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University of British Columbia  
Vancouver, B.C.  
V6T 1W5

Positions open to both female and male applicants.

## Clinical Instructors for Paediatric Unit and for the Obstetrics Unit

Required by Royal Inland Hospital, a 400 bed regional referral acute general hospital located in the B.C. interior. Excellent skiing and recreation area. Responsible for patient care oriented educational activities and staff development in the department of nursing service. Degree preferred but will consider post graduate with advanced experience. Must be eligible to register in B.C. Salary and benefits as per R.N.A.B.C. contract. 1979 rates \$1500 to \$1772 per month 1980 being negotiated.

Send resume to:

Personnel Director  
Royal Inland Hospital  
311 Columbia Street  
Kamloops, B.C.  
V2C 2T1



## Careers in Nursing Services in Canada's Ocean Playground

The Victoria General Hospital, Halifax, Nova Scotia is the Maritimes' largest teaching hospital associated with Dalhousie University. The close University liaison and our own extensive Continuing Education Program provides excellent avenues for learning.

Our nursing staff numbers in excess of 1,000 and we provide multiple opportunities for careers in the following areas:

**General Duty Nurses:** Our general nursing units cater to many specific sub-specialties in medicine and surgery.

**Intensive Care Nurses:** We have 5 specialized units; Coronary, Cardiovascular, Medical, Surgical, and Neurosurgery.

**Specialty Area Nurses:** This includes Burn Unit, Renal Unit, Emergency, Operating Room, Recovery Room, Out-Patients, and others.

**Nursing Administration:** Promotion is encouraged through an ongoing program of leadership development.

### Full Civil Service Benefits.

For details contact:

Mrs. Elizabeth Elliot, R.N.  
Personnel Department, 7th Floor  
Victoria General Hospital  
5788 University Avenue  
Halifax, Nova Scotia B3H 1V8

Telephone: 1 (902) 428-3484



## Nursing in the Sunny Palm Beaches

Picture yourself in the sunny Palm Beaches working at the most prestigious hospital in Florida. Good Samaritan Hospital has maintained the tradition of being the first in the latest hospital services and facilities. Our good name and outstanding history attest to our success.

A 326 bed, J.C.A.H. accredited hospital offering attractive salaries and benefits including:

- Active in-service orientation
- Continuing educational programs
- 37 1/2 hour week
- 5 day week
- No shift rotation
- Education and experience differential
- Fully paid Blue Cross/Blue Shield
- Shift differential and other employee benefits
- Seasonal employment welcome
- Patient-mix 90% under age 65

We will sponsor the appropriate employment Visa for qualified applicants. Attractive efficiency apartments available at far below commercial rates, overlooking the beautiful Lake Worth and located across the boulevard from the hospital.

Write:

Director of Personnel (305) 655-5511  
Good Samaritan Hospital  
Flagler Drive at Palm Beach Lakes Blvd.  
P.O. Box 3166  
West Palm Beach, Fla. 33402



## Offers R.N.'s

### An UNUSUAL OPPORTUNITY.

A.M.I. Will FURNISH One Way AIRLINE TICKET to Texas and \$500 Initial LIVING EXPENSES on a Loan Basis. After One Year's Service, This Loan Will be Cancelled

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★ HAS 50 HOSPITALS THROUGHOUT THE U.S.

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★ You can enjoy nursing in General Medicine, Surgery, ICC, CCU, Pediatrics and Obstetrics

★ A.M.I. provides an excellent orientation program. in-service training



### U.S. Nurse Recruiter

P.O. Box 17778, Los Angeles, Calif. 90017

★ Without obligation, please send me more information and an Application Form

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE ( ) \_\_\_\_\_  
LICENSES: \_\_\_\_\_  
SPECIALTY: \_\_\_\_\_  
YEAR GRADUATED: \_\_\_\_\_ STATE: \_\_\_\_\_



# MANITBA

Department of Health

**The School of Psychiatric Nursing,  
Selkirk Mental Health Centre  
is offering a Post - Basic Course in  
Psychiatric Nursing**

Registered Nurses currently licensed in Manitoba or eligible to be so licensed, with University credits in Introductory Psychology and Introductory Sociology.

The course is of ten months duration September through June, and includes theory and clinical experience in hospitals and community agencies, as well as six weeks nursing of the mentally retarded.

Successful completion of the program leads to eligibility for licensure with the R.P.N.A.M., as a Registered Psychiatric Nurse (R.P.N.).

For further information please write:

Director of Nursing Education  
School of Psychiatric Nursing  
Box 9600  
Selkirk, Manitoba R1A 2B5

## Waterford Hospital Career Opportunities For Registered Nurses

The Waterford Hospital, a fully accredited 400 bed Psychiatric Institution, affiliated with Memorial University School of Nursing and Medical School, has openings for Registered Nurses in all services, including new, expanded, and acute care services.

An orientation program is offered. Salary is on the scale of \$12,048 - 14,555 per annum. A Psychiatric Service Allowance of \$1,329 per annum is available in addition to basic salary. Both salary and allowance presently under review.

The Hospital is close to all amenities: shopping, transportation and recreation facilities.

Accommodations available in Hospital Residence at nominal cost.

Applications in writing should be addressed to the undersigned.

Personnel Director  
Waterford Hospital  
Waterford Bridge Road  
St. John's, Newfoundland  
A1E 4J8  
Telephone Number: (709) 368-6061, ext. 341

The Izaak Walton Killam Hospital for Children

## Staff Nurses

Intensive Care and Neo Natal Units

The Izaak Walton Killam Hospital for Children is a modern, progressive, 324-bed complex located in downtown Halifax. The I.W.K. is a teaching hospital affiliated with Dalhousie University and is the pediatric referral centre for Canada's Maritime Provinces.

Opportunities are available to work in our Intensive Care and Neo Natal Units. Extensive orientation and continuing education programs are offered in these specialties. Previous pediatric experience would be a definite asset.

If you are eligible for registration in Nova Scotia and are interested in a challenging position in pediatrics, please forward resume to:

Personnel Officer  
The Izaak Walton Killam Hospital for Children  
P. O. Box 3070  
Halifax, Nova Scotia B3J 3G9

## Challenging Opportunity

Memorial University of  
Newfoundland

- for a faculty member with a doctorate degree and demonstrated creativity and competence in curriculum development, research and teaching at the graduate level
- salary commensurate with qualifications and professional achievement
- graduate program in early stages of development

Send complete resume to:

Margaret D. McLean  
Director & Professor  
School of Nursing  
Memorial University of Newfoundland  
St. John's, Newfoundland  
A1C 5S7 Telephone (709) 737-6695

## Applications are invited for Faculty Positions

in the following areas

Community Health Nursing  
Medical-Surgical Nursing  
Parent-Child Nursing  
Mental Health - Psychiatric Nursing

Qualifications:

Preference will be given to advanced preparation in the clinical specialties

Salary and Rank: Commensurate with education and experience

For further information contact:

Miss Phyllis Jones  
Dean  
Faculty of Nursing  
University of Toronto  
50 St. George Street  
Toronto, Ontario  
M5S 1A1

## St. Francis Xavier University Department of Nursing Antigonish, Nova Scotia B2G 1C0

Telephone 902-867-2266  
902-867-3955

Applications are invited for the following positions for the academic year beginning August 1, 1980 in a basic baccalaureate program. Experienced teachers in both the acute care clinical setting and the classroom, in Medical-Surgical and/or Child Care.

- Doctoral degree preferred, Masters degree essential.
- Salary is in accordance with qualifications and experience.

Applications should be addressed to:

Ellen Murphy, Chairman  
Department of Nursing  
St. Francis Xavier University  
Antigonish, Nova Scotia B2G 1C0

## Royal Jubilee Hospital

Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

## Supervisor - Operating Room

Required to assume a leadership role in an expanding Operating Room Suite presently under construction with date of completion September 1980.

The applicant must have demonstrated leadership and administrative skills, post-graduate education in O.R. nursing and past experience as a Head Nurse or Supervisor.

Must be eligible for B.C. registration.

Prince George Regional Hospital is a 340 bed acute Regional Referral Hospital located in Central B.C.

Qualified applicants are invited to submit their resumes to:

Assistant Executive Director,  
Patient Services  
Prince George Regional Hospital  
2000 - 15th Avenue  
Prince George, B.C. V2M 1S2

## Nursing Co-Ordinator

Required by a 170-bed general hospital. Incumbent will be responsible for the development and implementation of nursing programs and systems; e.g. nursing histories, care plans and audits. The position reports to the Director of Nursing Services.

Qualifications:

B.Sc.N. with current Ontario Certificate of Competence and having experience in Nursing Education or Administration.

Resumes to:

Director of Personnel  
St. Joseph's Hospital  
519 King Street West  
Chatham, Ontario N7M 1G8



# Now, an unusual opportunity to "bridge the gap"

New graduate...a nurse wanting to specialize in pediatrics...a pediatric nurse wanting to specialize further? For all, Le Bonheur's new clerkship program includes an array of confidence-building classwork, clinical experience, preceptor guidance and formal recognition on completion. And, you are paid while you learn! After the basic program choose your pediatric specialty...intensive care, emergency nursing, infant care, surgical, medical or others. It will help you bridge the gap between education and specialized professional responsibilities. And it's at one of North America's most modern and complete pediatric centers.

In addition, Le Bonheur is the principal teaching hospital of the Department of Pediatrics, University of Tennessee. A \$13 million expansion provides the 225-bed facility with all new patient care areas. One-third of the beds are devoted to

in  
nursing!

such specialties as intensive care (18 beds), special care (newborns to 12 months), hemodialysis and neurological/neurosurgical. The hospital also has an ultra-modern emergency department with full-time Medical Director and a full spectrum pediatric ambulatory care service.

For those qualifying, Le Bonheur offers exceptional opportunities: Specialized positions within a personally rewarding environment...thorough orientation program...fully paid advanced education (tuition and books)...personal recognition incentives...competitive salaries and benefits...all within an atmosphere of friendliness, professionalism, variety and challenge.

Our Nurse Recruiter would like to hear from the seriously interested and qualified. Call her collect, (901)-522-3315...she will be visiting Canada soon.

Le Bonheur  
Children's  
Medical  
Center



In the heart of the Sunbelt... Memphis!

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## Registered Nurses

Applications from Registered Nurses are now being accepted for ongoing vacancies in a number of clinical areas. This large active treatment hospital offers challenge and an opportunity for professional growth in a dynamic atmosphere.

Candidates must be graduates of a recognized school of nursing, and be eligible for registration in Alberta. Post basic training and/or experience in specific clinical areas a definite asset.

Please apply in writing with details of education and experience to:

Personnel Department

**CALGARY GENERAL HOSPITAL**

841 Centre Avenue E.  
Calgary, Alberta T2E 0A1



## Registered Nurses

Planning your summer vacation?

Then by all means, include a visit to beautiful Vancouver in your plans. And while you're here, drop in and discuss your nursing career opportunities at **Shaughnessy Hospital**, an 1100 bed multi-level community teaching hospital.

We have full-time, part-time and float positions available as well as a 2 week orientation for RN's who wish to work on a casual basis only.

When you're in Vancouver please call:

Jane Mann  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C.  
V6H 3N1  
(604) 876-6767

## Advertising rates

For All  
Classified Advertising

\$20.00 for 6 lines or less  
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Rates for display advertisements on request.

Closing date for copy and cancellation is 8 weeks prior to 1st day of publication month.

The Canadian Nurses Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

*The Canadian Nurse*

50 The Driveway  
Ottawa, Ontario  
K2P 1E2



## Exploring the Many Faces of Opportunity

Opportunity wears many faces at Santa Monica Hospital Medical Center in Southern California. It can be the excitement and challenge of working as part of our Operating Room or Critical Care teams. It can also be in the achievement of your goals as you begin to play a more active role in management and/or supervision.

However, opportunities expand beyond your professional life in Southern California. The total scope of the active life is virtually unlimited... from wide, sunny beaches to near-by winter slopes... the opportunities are here.

If you would like more information about exploring the many opportunities now available to you, please forward the below coupon. Who knows, you may find a new definition for "opportunity".



**Santa Monica Hospital  
Medical Center**

1225 15th St., Santa Monica, CA 90404  
(213) 451-1511 Ext. 2537

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

An Equal Opportunity Employer M F

CN-4

## Registered Nurses

Come to work in scenic Corner Brook!

Registered nurses are needed for this 350 bed Regional General Hospital, with detached 60 bed Special Care Unit, serving the West Coast of Newfoundland.

The hospital offers good fringe benefits such as four weeks annual vacation and eight statutory holidays plus birthday holiday. In addition there is a hospital pension plan and a group insurance plan for all permanent employees.

Accommodation and assistance with transportation is available.

Negotiated Salary Scale:

1 January, 1979 — \$12,771.00 — 15,429.00  
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Service Credits recognized.

Interested applicants apply to:

Mrs. Shirley M. Dunphy  
Director of Personnel  
Western Memorial Regional Hospital  
P.O. Box 2005  
Corner Brook, Newfoundland  
A2H 6J7



# IMPORTANT MEMO

**To:** Registered Nurse Applicants For Overseas Jobs  
**From:** Hospital Corporation International  
**Subject:** Some Advice On Seeking Employment In The Field Of International Nursing.

Many organizations are offering overseas job opportunities in the health and hospital field these days. If you are interested and seriously considering an overseas or international assignment, here are some important points to consider and questions to ask — before and at your interview:

1

**Who is doing the interviewing and recruiting? What is their experience and background?**  
Make sure you are dealing with a reputable organization that is a true representative of your prospective employer. Be sure they have first hand knowledge of the location and facilities where you'd be living and working.

2

**Will I have to pay an employment fee? If so, for what and why?**  
Some independent agencies will charge you a sizeable fee just to send your resume somewhere else and can make no commitment to you. Other organizations do their own recruiting or can make commitments and they won't charge you an employment fee.

3

**What kind of organization or company am I dealing with? What is its primary business?**  
If it isn't the Health Care Business, first and foremost, you may want to investigate further: What are their qualifications, experience, standards, quality, etc?

**How realistic is the information and how much is offered about the job, the working conditions, culture, etc?**

If it all sounds exciting, glamorous, and positive, then the picture isn't realistic, it's "rose-colored". It *can* be adventurous and rewarding, but there are day to day drawbacks, frustrations, and difficulties to consider before you decide to go. And you should be told about *all* the details — don't accept generalizations.

4

**Will I be offered any assistance in preparing for overseas relocation, employment, and adapting to the new environment?**

Experienced, reputable organizations will show concern for you as an individual — and for your ultimate success — by assisting you with pre-departure processing requirements and preparations and by providing comprehensive pre-departure *and* post-arrival orientation programs.

5

**Will I be offered any assistance to relocate in another job when my contract is finished?**

Find out if the company can help you "get back in touch" after being away from home for two or more years. It's an important point that many individuals overlook — and so do many companies.

6

Hospital Corporation International, a member of the Hospital Corporation of America Group, is one of the most experienced and professional organizations providing international recruitment and human resource services in the health care and hospital related field.

If you are thinking about an overseas assignment, we invite you to explore the possibilities by exploring Hospital Corporation International. Ask us the questions; we'll give you the answers. You owe it to yourself.

If you are interested and would like more information, please send your resume to:

**International Human Resource Management (7)**

**Hospital Corporation International**

**One Park Plaza**

**Nashville, Tennessee 37203**

**HOSPITAL  
CORPORATION  
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The University of Western Ontario

## Graduate Program Coordinator

Applications are invited for the above position coordinating an expanding graduate program currently enrolling 35 students. Canada's first M.Sc.N. program offers majors in Nursing Education and Nursing Administration.

Duties involve overall program coordination, delegated administrative functions, curriculum development and teaching.

Qualifications include Ph.D., university teaching experience, and demonstrated clinical competence. Previous administrative experience is desirable.

Salary is commensurate with academic and experiential background.

Send curriculum vitae and references to:



**Dr. Beverlee Cox, Dean**  
Faculty of Nursing  
The University of Western Ontario  
London, Ontario, Canada

## Moving, being married?

Be sure to notify us in advance.

Attach label from  
your last issue or  
copy address and  
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New (Name)/Address

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*Please complete appropriate category*

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reg. no./perm. cert./lic. no.

☐ I am a personal subscriber

Mail to: *The Canadian Nurse*, 50 The Driveway, Ottawa,  
Ontario K2P 1E2

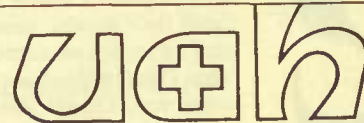
## Registered Nurses

1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including:

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education Programs.  
Post Graduate Clinical Courses in Cardiovascular—  
Intensive Care Nursing and Operating Room Nursing.

Apply to:  
Recruitment Officer — Nursing  
University of Alberta Hospital  
8440 — 112th Street  
Edmonton, Alberta  
T6G 2B7



**University of  
Alberta Hospital**

Edmonton, Alberta



## Nursing Opportunities in Vancouver Vancouver General Hospital

If you are a Registered Nurse in search of a change and a challenge — look into nursing opportunities at Vancouver General Hospital, B.C.'s major medical centre on Canada's unconventional West Coast. Staffing expansion has resulted in many new nursing positions at all levels, including:

**General Duty (\$1305. - 1542.00 per mo.)**

**Nurse Clinician**

**Nurse Educator**

**Supervisor**

Recent graduates and experienced professionals alike will find a wide variety of positions available which could provide the opportunity you've been looking for.

For those with an interest in specialization, challenges await in many areas such as:

**Neonatology Nursing      Intensive Care  
(General & Neurosurgical)**

**Inservice Education      Cardio-Thoracic Surgery**

**Coronary Care Unit      Burn Unit**

**Hyperalimentation      Paediatrics  
Program**

**Renal Dialysis & Transplantation**

If you are a Nurse considering a move please submit resume to:

Mrs. J. MacPhail  
Employee Relations  
Vancouver General Hospital  
855 West 12th Avenue Vancouver, B.C. V5Z 1M9



## University of Western Ontario Faculty of Nursing

Applications are invited for teaching positions in undergraduate and graduate programs. Rank Open.

Master's or doctorate degree required. Preference will be given to candidates with teaching experience and clinical specialization. Candidates must be eligible for registration in Ontario.

Salary commensurate with preparation and in accordance with the University of Western Ontario policies. Appointments are subject to availability of funds.

Send complete resume to:

Dr. Beverlee Cox, Dean  
Faculty of Nursing  
Health Sciences Addition  
The University of Western Ontario  
London, Ontario. N6A 5C1

Winnipeg Municipal Hospital requires

**Licensed Practical Nurses**

**Registered Nurses**

**Bachelor of Science in Nursing**

Professionals wishing to become part of the team approach to Gerontological Patient Care.

To bridge the gap between education and practice, the hospital maintains a comprehensive orientation program followed by specific Nursing Unit orientation programs. Continuing Education Inservice programs are carefully planned to promote both quality patient care and job satisfaction.

Specialty areas include Rehabilitation, Palliative Care, Long Term Care and an expanding Respiratory Unit.

A 2 week hospital orientation will commence on March 3rd, 1980.

Salary negotiable - allowance for Academic Attainment.

Interested personnel please submit resume and names of references to:

Mrs. June R. Roberts  
Personnel Officer  
Winnipeg Municipal Hospital  
1 Morley Avenue  
Winnipeg, Manitoba  
R3L 2P4



OPPORTUNITY

Alberta

**Nurses**

Applications are invited for positions at Alberta Hospital, Edmonton, a 650 bed active treatment psychiatric hospital, located 4 km. outside of Edmonton. Successful candidates must be graduates from a recognized School of Nursing and eligible for registration in their professional association; willing to work shifts. Vacancies exist in Admissions, Forensic, Rehabilitation, and Geriatric Services. Note: Transportation is available to and from Edmonton. Accommodation is available in the Staff Residence.

Salary \$1,229 — \$1,445 per month (Starting salary based on experience and education)

Competition #9184-9

This competition will remain open until a suitable candidate has been selected.

Qualified persons are invited to phone, write or submit applications to:

Personnel Administrator  
Alberta Hospital, Edmonton  
Box 307, Edmonton, Alberta  
T5J 2J7  
Telephone: (403) 973-2213



# Wish you were here



## ...in Canada's Health Service

Medical Services Branch  
of the Department of  
National Health and Welfare employs some 900  
nurses and the demand grows every day.

Take the North for example. Community Health  
Nursing is the major role of the nurse in bringing health  
services to Canada's Indian and Eskimo peoples. If you  
have the qualifications and can carry more than the  
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Hospital Nurses are needed too in some areas and  
again the North has a continuing demand.

Then there is Occupational Health Nursing which in-  
cludes counselling and some treatment to federal public  
servants.

You could work in one or all of these areas in the  
course of your career, and it is possible to advance to  
senior positions. In addition, there are educational  
opportunities such as in-service training and some  
financial support for educational leave.

For further information on any, or all, of these career  
opportunities, please contact the Medical Services  
office nearest you or write to:

Medical Services Branch  
Department of National Health and Welfare  
Ottawa, Ontario K1A 0L3

Name

Address

City

Prov.



Health and Welfare  
Canada

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Canada

## Are You a Nurse?

### Here's an Opportunity To Be One.

#### Primary Nursing

.....at the New Regional Hospital means having direct  
responsibility for the nursing care of your patient, his family,  
and working with the doctor as a colleague.

#### Accountability

.....as a primary nurse means the outcome of your patient's  
care is the measure of your effectiveness.

#### Satisfaction

.....results from your role as a professional and the significant  
part you play in the care of your patient.

**PUT IT TOGETHER** with the new 300 bed Fort McMurray  
Regional Hospital Opening in November, 1979.

Want to know more about your opportunities in our **total  
patient care** facilities?

Call Penny Albers at (403) 743-3381

or

Write for an information package:

Personnel Department  
Fort McMurray Regional Hospital  
Fort McMurray, Alberta  
T9H 1P2

## Royal Alexandra Hospital

This 932 bed active treatment hospital invites  
applications from nurses across Canada.

We offer experience in all areas of patient care  
including intensive care, neonatal intensive care  
and obstetrical perinatology. The extended work  
day and compressed work week is currently in  
effect in the Intensive Care areas.

Applicants must be eligible for registration with the  
Alberta Association of Registered Nurses.

Please direct inquiries to:

Personnel Officer  
Nursing Recruitment  
Royal Alexandra Hospital  
10240- Kingsway Avenue  
Edmonton, Alberta  
T5H 3V9





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P.O. Box 482  
Ardmore, Pennsylvania 19003  
Telephone: (215) 363-6063

### *Advertising Manager*

Gerry Kavanaugh  
The Canadian Nurse  
50 The Driveway  
Ottawa, Ontario K2P 1E2  
Telephone: (613) 237-2133

## Director, Extension Course in Nursing Unit Administration

Applications are invited for the position of Director, extension course in Nursing Unit Administration. The incumbent will be responsible for the conduct of the program and accountable to a Joint Committee composed of representatives of the Canadian Nurses Association and the Canadian Hospital Association.

Applicants should have advanced academic preparation, a Master's degree or equivalent, relevant background of experience in nursing administration and/or nursing education and be bilingual.

The position should be filled in May, 1980.

Interested applicants are asked to submit their curriculum vitae, in confidence, by 5 April 1980, to:

**The Selection Committee  
Nursing Unit Administration Course  
410 Laurier Avenue West  
Ottawa, Ontario  
K1R 7T3**

## Nursing Coordinator

### **OBS and GYN**

The Nursing Coordinator is a senior staff position, responsible for the Nursing Administrative and Clinical Coordination of the OBS/GYN Units including the Regional Perinatal Service. The OBS Service has approximately 3100 deliveries per year. Women's College Hospital is a 391 bed University teaching hospital in downtown Toronto.

### **Qualifications:**

- B. ScN. or equivalent
- Minimum of 5 years clinical experience in OBS
- Administrative experience
- Eligible for registration in Ontario

Please submit resume to:

**Director of Nursing  
Women's College Hospital  
76 Grenville St.  
Toronto, Ontario  
M5S 1B2**



# Debrisan<sup>®</sup>

## cuts the cost of decubitus care

### by controlling infection fast

Debrisan sucks bacteria and toxins out of decubitus ulcers. The ulcer is quickly cleansed, healthy granulation appears, and healing can begin.

"These (wet, exudative ulcers) averaged two days to clear the superficial infection and five days from the onset of therapy to appearance of good granulation tissue in the ulcer base."<sup>1</sup>

### by relieving pain and odour fast

"All patients in whom rest pain was present at the start of treatment noticed almost immediate relief of the rest pain when Debrisan was applied to the wound."<sup>2</sup>

"Debrisan was commenced and the following day, the smell had disappeared."<sup>3</sup>



Day 0 Infected, heavily exuding decubitus ulcer on left hip.



Day 2 Exudate diminished. Erythema and edema reduced.



Day 14 Clear, healthy granulation base; grafted successfully.



Day 0 Infected exuding decubitus ulcer on knee.



Day 4 Clear, healthy granulation base.



Day 14 Ulcer healing after Debrisan discontinued.



Day 0 Undermined sacral decubitus ulcer infected with *Pseudomonas* and *E.coli*.



Day 7 Surgically debrided before Debrisan therapy and after 7 days, infection controlled.



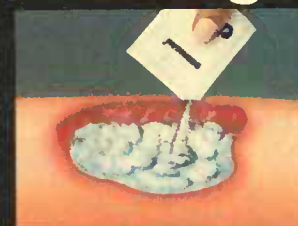
Day 28 Appearance on healing.

### by saving valuable nursing time

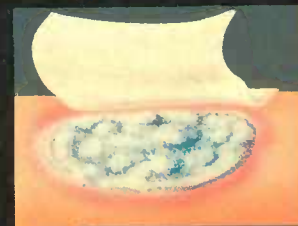
Only one Debrisan change a day\* is needed. Debrisan therapy can be stopped as soon as all signs of infection have gone and the ulcer is clean and granulated.

"Debrisan appears to be, in my opinion, just what we as nurses are seeking."<sup>4</sup>

\*Two, if exudation is very heavy.



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#### References

1. Lim LT, Michuda M, Bergen JJ, *Angiology* 29:3, Sept 1978.
2. Bewick M, Anderson A, *Clin Trials J* 15:4, 1978.
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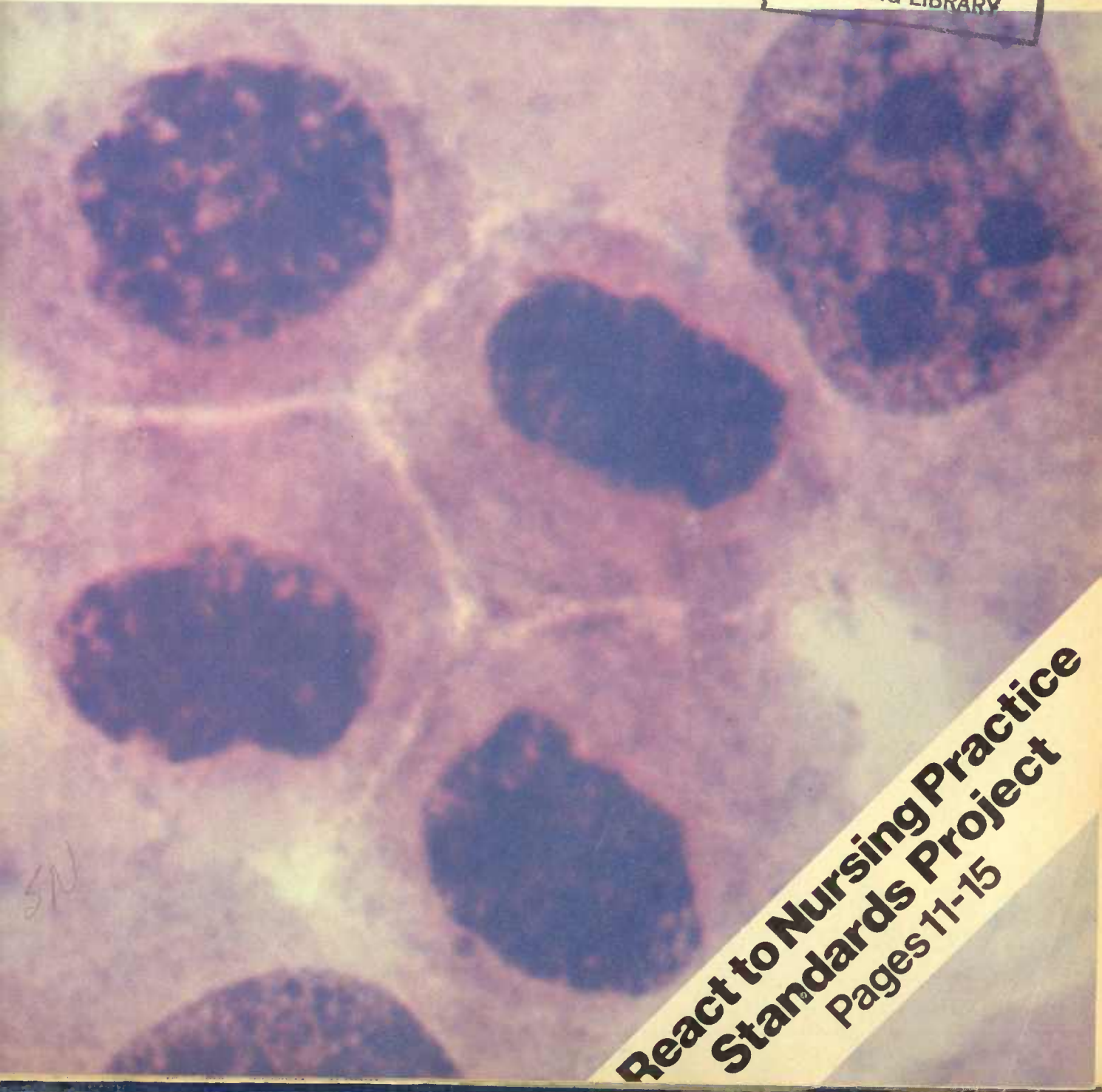
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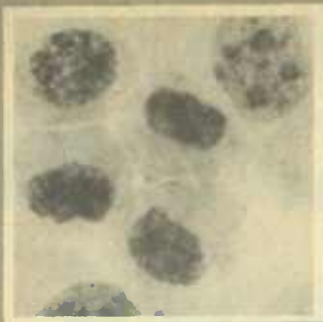
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# The Canadian Nurse

May 1980

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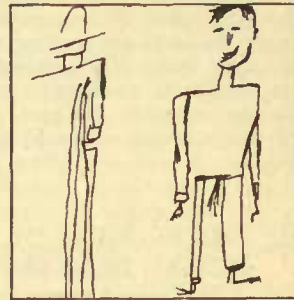
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*"The settlement was overdue but it's still less than they owe us. They've corrected the discrepancy but RN's, on the whole, will have to be better paid if the Feds hope to attract them to work in the penitentiary system."*

— *Leona Mollis, the nurse at the federal correctional institution at Springhill, N.S., who filed the original complaint leading to the recent precedent-setting pay settlement based on the principle of "equal pay for work of equal value."*

Gloria Blaker

## SOME OF US ARE MORE EQUAL THAN OTHERS

"Sex discrimination in the labor market generally results in some combination of unequal pay for equal work and unequal employment hiring and promotion opportunities."\* Although both forms of discrimination are inter-related, sex discrimination in pay results from a vicious, self-fulfilling circle which is the result of subjective beliefs. Females are concentrated in jobs which are logical extensions of traditional housewife chores. Because these jobs — child care, nutrition and nursing — are so close to the unpaid work that women normally do in their homes, they are not valued, rewarded and respected as are the traditional male tasks which have had a dollar value on them ever since currency began.

Females are erroneously screened into low productivity, low-wage jobs and in this fashion, an initially discriminatory subjective belief becomes self-fulfilling and male-female wage differentials persist. Employers readily accept subjective beliefs or differential abilities because this justifies their discriminatory behavior and, therefore, wage differentials persist even in the face of competitive pressures.

Even though Treasury Board has gone on the record in support of the elimination of sex discrimination, the board's position in bargaining has consistently been that of paying salaries comparable to those paid by other employers in Canada, thereby perpetuating this self-fulfilling circle. At first glance this bargaining position appears to be an impartial or non-discriminatory position. On second glance, of course, this particular position merely serves to continue the existing discrimination; therefore, salary levels for occupations primarily filled by women will be consistently lower than occupations primarily filled by men which have similar requirements for professional training.

The Professional Institute contends that the federal government could and should take the lead in establishing more equitable pay rates for predominantly female occupational groups and thereby take the lead in eliminating sex discrimination in pay practices.

It is a fact that the Government still hires fewer women than men, even though more and more Canadian women are working, regardless of marital status.

The Government still concentrates female public servants in occupational ghettos, particularly the occupational and physical therapy group, the home economics group, composed mostly of dietitians, and the nursing group.

With the enactment of the Canadian Human Rights legislation and the subsequent establishment of the Commission, we thought that at last an effective agency had been provided with sufficient clout to force an employer to refrain from actions which could be shown to be discriminatory.

So, the Professional Institute decided to lodge a complaint on behalf of six of its nurses employed in federal penitentiaries at Springhill, Nova Scotia and Dorchester, New Brunswick. Not only did these nurses carry out the same functions as male colleagues in the institution who were classified as Hospital Technicians, but in fact, some five years previously, the positions filled by both sets of employees had been upgraded to require registered nurse training. In spite of this, the six female nurses were receiving salaries nearly 9 per cent lower than the male Hospital Technicians.

All efforts to redress the situation at the bargaining table over the past few years had been rebuffed by the Treasury Board. Now that a complaint was lodged, it was up to the commission to set up its own investigation, and as a result it was very soon satisfied that there was in fact a case of discrimination in

pay administration for the nursing group.

At first the Treasury Board persisted in its refusal to acknowledge discriminatory practice in its pay administration, but finally in October 1979, after the commission threatened to appoint a tribunal which would have the power to impose a verdict, such an admission was forthcoming.

All that remained was to arrive at an agreement for a settlement to redress the situation cited at the beginning of this article, a step that took four months and finally resulted in the announcement by the Human Rights Commission on February 25, 1980.

It is interesting that the federal government should be the first employer found guilty of contravening legislation enacted by itself. At the same time it is also heartening to realize that this legislation is not a mere paper tiger as some of its more cynical advocates had feared. Even now there remain reservations, particularly in connection with some of the procedures adopted by the commission but, in the wake of this first decision, the outlook is certainly optimistic.

The overall situation, however, is still far from settled. The case of the penitentiary nurses might well have been dealt with under provincial legislation which exists in some provinces calling for "equal pay for equal work". Perhaps the most important feature of the federal legislation under which the nurses' case was heard, is the provision calling for "equal pay for work of equal value". This is a big improvement over previous legislation, but it still falls far short of the programs and enforced mandatory requirements that characterize equal pay and equal rate policies in the United States.

The cost of implementing equal pay for work of equal value demands formal solutions. It is unlikely that there will be significant progress in the direction of

equal pay for work of equal value without strong government action, including provision of adequate resources at all levels of the federal bureaucracy.

These costs are balanced by benefits to the employer for efficient use of human resources and the higher worker morale generated by fair treatment. After all, child labor which we now regard as morally reprehensible, was also economically beneficial to industry. We saw that child labor was wrong and the present problem is just as obvious.

The Canadian Human Rights Commission has shown us the way. Now the institute urges the federal government to provide formal solutions and to pay the cost of implementing strong programs which will result in equal pay for work of equal value. ♣

Gloria Blaker, BN, is negotiator for the Professional Institute of the Public Service of Canada (Federal Nursing Group).

\*Morley Gunderson in "Discrimination in Wage Payments"

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# input

A day to remember  
March 4, 1980 is a date to remember in the history of nursing: on that day, in a small amphitheatre in the Government Conference Centre in Ottawa, the sun shone on the profession and on its delegation when CNA presented its brief to former Supreme Court Justice Emmett Hall.

CNA president Helen Taylor provided an overview of the brief by highlighting the eight recommendations. The association challenged the commission to *allow the emergence* of a health insurance program that would stimulate development of primary health care services, permit the introduction of new entry points and promote the appropriate utilization of qualified health personnel.

Ginette Rodgers, CNA's member-at-large for nursing administration, elaborated on community health care facilities that would be directed towards better service at less cost.

Justice Hall explored the possibility of using the school as a community health centre location. It seemed that both the school and the workplace might be appropriate locations for a team of health care workers.

The CNA recommendation that "remuneration of all health personnel be by salary" carried with it the comment that many physicians see no clear avenue for reward for high quality service. Many situations do not require the input of a physician but as long as the physician is paid a fee for service he is going to be compromised by quantity of service versus quality.

A recommendation for better preventive, diagnostic and ambulatory care programs through various community-based entry points was presented and the question of human resources available to man new community-based centers was explored. It was pointed out that a variety of health professionals would be required to staff community centers.

In a discussion of nursing manpower, CNA executive director, Dr. Helen Mussallem noted that the number of nurses entering

and leaving the profession was cyclical. She stated that the profession was encouraging the development of a number of refresher courses, workshops and short term courses. No rigorous studies have been completed assessing the degree of job satisfaction perceived by nurses but, generally speaking, the higher the level of an individual's education the more likely they would be to return to the profession.

President-elect Shirley Stinson spoke to CNA's recommendation that a Health Science Research Council be established to focus on the study of health services, the system of delivery and its effectiveness. Dr. Stinson stated that nurses have tried to initiate research into the science of the practice without great success.

Two final recommendations encouraged governments to re-institute the National Health Survey and to adopt, as a priority, better and broader health education programs to sensitize consumers to the costs of acute care services.

Throughout the exchange, our delegation appeared organized, poised, thoroughly briefed and ready to respond to any questions. The efforts and frustrations that preceded the day of presentation may have been tremendous. The end result, however, was a well polished, well presented document that generated the esteem of many national health agencies and demonstrated once again, for all to see, the benefits that can be attained by having a national body speak on behalf of the total profession.

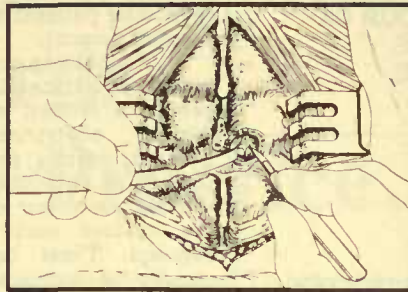
That day, above any other day for a long time, I was extremely proud not only of our national representatives and their work on our behalf, but also of being a nurse.

Congratulations CNA for a job well done.  
—Marjorie W. Hayes, RN, BScN, MScN (ed.), Director, Health Computer Information Bureau, Canadian Hospital Association/Canadian Medical Association/Canadian Organization for Advancement of Computers In Health



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### A comprehensive role Author Mohamed

Rajabally (January) argues that the comprehensive examination for nurse registration is in response to changes in nursing education and is inconsistent with the practice of nursing.

I would argue that nursing education is responding to the needs of nursing practice, the need for practitioners who can respond to the unique set of nursing problems that individual patients and their families present.

Patients do not present nice compartmentalized problems labeled medical, surgical, obstetrical and pediatric nursing; patients *do* present an individual mix of nursing problems to which the modern nurse must respond. These demands require the mobilization of a wide range of nursing knowledge and skill.

The Canadian Nurses Association Testing Service should be congratulated for its response to changing nursing needs and encouraged to continue to examine the problems which may result from these changes.

Solutions can be found to the problems presented by failing candidates. How many items do we really need for a valid and reliable examination? Is it possible to give a sub-score report so that failing candidates may know their areas of weakness? We must not abandon a forward step because of some problems which no doubt can be resolved.

Canadian nurses should be proud and support this forward step.

—Patricia Stanojevic, RN,  
Etobicoke, Ontario.

### A managerial role

The statement by Frances M. Tufts that, "When nurse X has shown her inability to function in any other area, she is sent to OBS unit", is very sweeping and one I suspect not founded on analyzed data. The implication is that this department is staffed by numbers of incompetent general staff and management nurses. I personally have more faith in the integrity of nursing than to believe this.

Head Nurses should not play the role of "hatchet women"; rather, with a sound performance appraisal system in place, clearly define the weakness of the individual

worker, set deadlines for improvement and options if expectations are not met. The role of the head nurse as a manager of staff is of paramount importance but have we in education and senior management helped him/her develop the necessary skills? I do agree we have to look to education and inservice to develop knowledge and skill.

OBS provides a challenge, as do many other services that are dynamic and respond to the medical, technical and social changes inherent in our world of today.

I am not in doubt that the writer's intent was sincere, but I am concerned that the self-confidence and integrity of some OBS nurses may have been damaged by such comments.

—M. Gwen Heffernan,  
Director of Nursing Staff  
Education, Ottawa Civic  
Hospital, Ottawa.

### A busy spot

In response to Frances Tufts' letter (February), our OBS department is not a "dumping" ground for incompetent or over-the-hill nurses. No transfers are made to any department to my knowledge: vacancies are filled by requested transfers from other departments.

Our OBS-GYN ward is one of the busiest in the hospital. Nursing and other staff must be able to cope with the confusion resulting from many admissions and discharges, a wide range of age groups, normal deliveries, caesarean sections, prenatals—toxemia, hyperemesis, bleeding, as well as hysterectomies, vaginal repairs, ectopics, other pelvic and perineal surgery, D & C, abortions — just to mention some of them.

Just like other floors, we also have to treat the medical aspects of our patients — depression, diabetes, hypertension, drug dependency and abuse; again, just to mention some of them.

The hospital inservice keeps us abreast of medical and nursing developments and as well, our own area has lectures and discussions frequently. We also do a great deal of teaching.

I think Frances Tufts had better take another look!  
—Gloria Norwick, RN,  
Oshawa, Ontario. ♡





CNA

## PROJECT REPORT

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# Development of a Definition of Nursing Practice and Standards for Nursing Practice.

**What do national standards for nursing practice mean to you?** To help you answer this important question we're giving you, on these four pages, draft statements drawn from the work that began in July 1979 by the CNA Task Group. It's a priority 1978-80 biennium project to be presented to the CNA Board of Directors in Vancouver in June. **What you read here is a substantial basis for the presentation to be made - the work isn't over yet and that's why we need your help now...** It's important that you have the opportunity to participate in the final development of a definition of nursing practice and standards for nursing practice along with your national association.

---

### Where it started...

One of the initial premises of the project was to utilize a conceptual model approach to the development of a definition of nursing practice and standards for nursing practice.

There is a very real need for the nursing profession as a vital member of the multidisciplinary health care team, to identify and clarify nursing's unique contribution to society — to determine how it meets society's needs. **What is the role of the nurse? What do nurses do?**

A conceptual model for nursing is a mental image, or a way of looking at nursing, usually based on or derived from theory and/or practice. It provides the direction and specificity to make explicit nursing's unique independent role.

Standards for nursing practice based on a conceptual model approach provide the basis for measuring the effectiveness of nursing actions.

Several conceptual models for nursing were studied by the Task Group. Although each conceptual model has merits and limitations, the decision made by the Task Group and endorsed by the CNA board of directors, was *not* to choose a *specific* model, but to *adopt* the principle that a conceptual model be used to guide nursing practice regardless of the setting in which that practice occurs. This principle was built into the definition and the standards.

The Task Group adopted these principles:

- We recognize and endorse the use of a conceptual model for nursing practice, education, research and administration in any setting.
- Respecting freedom of informed choice, we will not impose upon others, our choice of any one of the various conceptual models for nursing that exists.
- This freedom of choice will allow for the utilization of a number of conceptual models for nursing, their eventual testing and further refinement as well as the construction of new models.
- We believe that the use of a conceptual model for nursing will contribute to improved quality of nursing practice, since it provides direction for behavioural indicators required to evaluate that practice.





# PROJECT REPORT

As a result of the decision of the Task Group not to select a specific conceptual model upon which to base standards for nursing practice and because each conceptual model includes a distinct conceptualization of nursing from which a definition of nursing practice could be derived, the committee determined that it would be incongruous to develop a restrictive definition of nursing practice.

## Philosophical Statement About Nursing

Nursing exists in response to a need of society, and holds ideals related to man's health throughout his life span and includes the promotion, maintenance and restoration of health, the prevention of illness, the alleviation of suffering and the ensuring of a peaceful death when life is no longer able to be sustained. Nurses value a holistic view of man and regard him as a biopsychosocial\* being who has the capacity to set goals and make decisions and who has the right and responsibility to make informed choices congruent with his own beliefs and values. Nursing, a dynamic and supportive profession, is rooted in caring, a concept evident throughout its four fields of activity: practice, education, research and administration.

In assisting man to achieve and maintain optimal health, nurses practice in a variety of settings and concurrently perform *independent, interdependent and dependent* functions. Nursing's unique independent contribution to health is made explicit through any one of the various conceptual models for nursing, each of which is a conception, or way of looking at nursing sufficiently precise as to provide direction for practice, education, research and administration. Interdependent functions are evident when nurses collaborate with other health-directed and health-related workers, whereas dependent functions are evident when nurses perform activities under the direction of others such as carrying out physicians' orders. The three overlapping functions all contribute to man's attainment of optimal health. Nurses value the on-going discovery, acquisition and critical application of relevant knowledge, attitudes and skills; these are prerequisites for the promotion of excellence in nursing practice, education, research and administration. In their search for excellence, nurses are committed to the development and implementation of standards for their own profession.

\*The generally accepted term describing man as "biopsychosocial" is meant here to include among others, spiritual, intellectual, physical, cultural and environmental dimensions.

## Toward a Definition of Nursing Practice

Nursing practice can be defined generally as a dynamic, caring, helping relationship in which the nurse assists the client to achieve and maintain optimal health. The nurse accomplishes this goal by applying knowledge and skills from nursing and related fields using the nursing process, the substance of which is determined by a conceptual model for nursing.

A specific definition of nursing practice necessarily depends upon the conception of nursing held.\* There exist several conceptual models for nursing and the selection of a particular model is a matter of informed choice. It is therefore necessary that nurses determine, according to the model chosen, what will be their specific definition of nursing practice\* in their setting. The definition of nursing practice must influence and be consistent with legislation governing or affecting the profession, with the code of nursing ethics, and with policies, procedures and directives in a particular setting.

\*For example, if Roy's conception of nursing were selected, nursing practice would be oriented to the promotion of man's adaptation in his four adaptive modes, the nurse would assume the role of facilitator; her intervention would consist of manipulating the focal, contextual and residual stimuli that provoke the adaptive or non-adaptive responses of man. On the other hand, if Henderson's conception of nursing were selected, nursing practice would be oriented to the independence of man in the satisfaction of his fundamental needs, the nurse would assume a complementary-supplementary role to supply strength, knowledge or will; her intervention would consist of reinforcing and completing man's capacities so that he would return to independence in the satisfaction of his needs.

## Beliefs About Standards for Nursing Practice

- Standards for nursing practice must be developed by members of the nursing profession.
- Standards for nursing practice must express what is desirable nursing practice in Canada.
- Standards for nursing practice must be broad enough to apply to any practice setting.
- Standards for nursing practice are a prerequisite to the evaluation of nursing practice, since they provide a baseline for measurement.
- Standards for nursing practice must include expectations about the independent, interdependent and dependent functions of nurses.
- Standards for nursing practice must include expectations related to a conceptual model for nursing, the nursing process, the helping relationship, and professional responsibilities.
- Standards for nursing practice must respect the freedom of informed choice with regard to the selection of a conceptual model to be used in a given setting.
- Standards for nursing practice will influence and be influenced by not only nursing practice, but also nursing education, research and administration.
- The adoption of standards for nursing practice will help clarify nurses' areas of accountability, since standards provide the health agency and the client with a basis for evaluation of nursing practice.
- Standards for nursing practice must be subjected to continuous reevaluation.
- The adoption of standards by nurses in practice will contribute to the continued improvement of nursing practice.

## How are Standards judged?

Here are some characteristics...

- relevant to the domain under consideration
- directed toward an ideal
- realistic
- acceptable
- attainable
- understandable
- developed by experts in the domain
- based on current knowledge
- phrased in positive terms
- indicative of acceptable performance
- amenable to measurement

We have organized the standards into four groupings because we believe that the nurse uses the nursing process as her method for practice and the model as her conceptual base. The nature of her interaction with the client is a helping one. Because she is a professional and practices in a variety of settings, standards related to professional responsibilities were developed.

It is important to remember that the four are necessarily interrelated and occur together.





# PROJECT REPORT

## DRAFT STANDARDS FOR NURSING PRACTICE

### STANDARDS RELATED TO A CONCEPTUAL MODEL FOR NURSING

Criterion Variable	Nursing Standards	Nursing Behaviours
The goal of nursing	<i>Nursing practice requires the nurse, in any setting at any time, to have:</i> 1. a clear conception of the distinct goal of nursing	The Nurse: 1.1 expresses the specific goal of nursing which nursing seeks to attain 1.2 communicates the goal of nursing to other members of the health team 1.3 states how the goal of nursing contributes to the overall goals of the health team 1.4 describes nursing actions which are consistent with the expressed goal of nursing 1.5 performs nursing actions (cf. nursing process standards) which are consistent with the expressed goal of nursing
The client	2. a clear conception of the client toward whom nursing is directed	2.1 expresses her clear conception of the client 2.2 describes the kind of data to be collected according to her conception of the client 2.3 demonstrates her conception of the client by the kind of data she collects (cf. nursing process 1.1)
The role of the nurse	3. a clear conception of her role as a health professional in response to health needs of society	3.1 describes her specific role as a nurse 3.2 describes her conception of her role in relation to data analysis and intervention 3.3 demonstrates her conception of her role in data analysis and intervention (cf. nursing process 2.1, 3.1)
The origin of difficulty	4. a clear conception of the source of the client's actual or potential difficulty	4.1 states the source of difficulty as defined by the conceptual model for nursing 4.2 describes how she will interpret data according to her conception of the type of client problems that fall within the scope of her responsibility 4.3 demonstrates her conception of the source of client difficulty in her analysis of data (cf. nursing process 2.1)
The focus and modes of intervention	5. a clear conception of the focus and modes of nursing intervention	5.1 states her conception of the focus and modes of nursing intervention as defined by the conceptual model for nursing 5.2 describes her intervention in relation to its focus and according to the means she has at her disposal 5.3 demonstrates this conception in the actions she plans and carries out (cf. nursing process)
The expected results of nursing activities	6. a clear conception of the expected results of nursing activities related to the goal of nursing as expressed in the conceptual model for nursing	6.1 describes expected results of her nursing activities as defined by the conceptual model for nursing 6.2 demonstrates her conception of the expected results in the evaluation of her nursing activities

### STANDARDS RELATED TO THE NURSING PROCESS

Criterion Variable	Nursing Standards	Nursing Behaviours
Collection of Data	<i>Nursing Practice requires the nurse to:</i> 1. collect data in accord with her conception of the client, and with her interdependent and dependent functions	The Nurse: 1.1 systematically and continuously collects data that are relevant to her conception of the client (cf. conceptual model 2.3) 1.2 systematically and continuously collects data necessary for her to fulfill her interdependent and dependent functions 1.3 determines the client's expectations for care 1.4 uses all available sources for data collection including: client, family, relevant others, records, the nurse's own knowledge and experience 1.5 employs various techniques in data collection including: interview, consultation, physical examination, observation, measurement 1.6 treats data with regard for the confidentiality of those concerned 1.7 makes available relevant data to appropriate persons
Analysis of Data	2. analyze data collected in accord with her conception of the client's source of difficulty and consistent with her interdependent and dependent functions	2.1 examines and interprets the data 2.2 validates with the client and/or others when possible, her interpretation of the data collected 2.3 identifies with the client actual and/or potential problems as suggested by the source of difficulty 2.4 sets priorities for resolution of identified problems 2.5 communicates with appropriate others regarding identified problems
Planning of the intervention	3. plan her nursing actions based upon the identified actual and potential client problems and in accord with her conception of the focus and modes of intervention as well as nursing actions which arise from her interdependent and dependent functions	3.1 identifies short and long term objectives of nursing actions in collaboration with the client and relevant others (cf. conceptual model 5.3) 3.2 states the objectives in behavioural terms specifying the desired results 3.3 states a reasonable time period for achievement of these objectives 3.4 considers environmental conditions which could affect achievement of objectives 3.5 identifies required resources 3.6 considers a number of nursing actions* in accord with the specified focus and modes of intervention





# PROJECT REPORT

## DRAFT STANDARDS FOR NURSING PRACTICE

### STANDARDS RELATED TO THE NURSING PROCESS

Criterion Variable	Nursing Standards	Nursing Behaviours
Planning of the Intervention	<i>Nursing practice requires the nurse to:</i> 3. plan her nursing actions based upon the identified actual and potential client problems and in accord with her conception of the focus and modes of intervention as well as nursing actions which arise from her interdependent and dependent functions	The Nurse: 3.7 selects nursing actions based on the highest probability of their effectiveness 3.8 plans nursing actions that derive from her independent, interdependent and dependent functions 3.9 communicates with appropriate others regarding the planned interventions
Implementation of the Intervention	4. perform nursing actions which implement the plan	4.1 encourages client participation whenever possible in carrying out nursing actions to meet objectives (cf. helping relationship 1.9) 4.2 carries out nursing actions demonstrating required knowledge, attitudes and skills 4.3 utilizes appropriate resources 4.4 manipulates the environment to meet the objectives 4.5 communicates with appropriate others regarding nursing actions
Evaluation	5. evaluate all steps of the nursing process in accord with her conceptual model for nursing and consistent with her interdependent and dependent functions	5.1 observes the results of her nursing actions 5.2 compares the results of nursing actions with those stated in the short and long term objectives 5.3 judges, within the context of client participation the degree to which the objectives have been met in accord with her conception of the expected results (cf. conceptual model 6.2) 5.4 communicates with appropriate others regarding her evaluation 5.5 revises the objectives, priorities and nursing actions as indicated 5.6 implements the modified plan of action 5.7 continues in cyclical fashion the entire nursing process until the client-nurse relationship is terminated

\* Nursing actions include teaching, supporting, counselling, informing, referring, providing care (comfort measures, maintenance, preventive, diagnostic, therapeutic). Canadian Nurses Association *A Blueprint for a Comprehensive Examination for Nurse Registration/Licensure* (Ottawa: May 1977), p. 4.

### STANDARDS RELATED TO THE HELPING RELATIONSHIP

Criterion Variable	Nursing Standards	Nursing Behaviours
Entry	<i>Nursing Practice requires the nurse to:</i> 1. initiate the helping relationship with the client	The Nurse: 1.1 identifies herself and explains her role and responsibility to the client at her earliest opportunity 1.2 ensures client understanding 1.3 ensures her communication is purposeful, appropriate and relevant 1.4 shows undivided attention through verbal and non-verbal behaviour 1.5 invites client participation in the helping relationship 1.6 ascertains what the client expects to give and to get from the relationship 1.7 establishes the duration of the relationship with the client in order for each to prepare for eventual termination of the relationship 1.8 discusses confidentiality with the client indicating with whom any information will be shared and why 1.9 sets realistic nursing care objectives in collaboration with the client 1.10 makes explicit her availability and approach-ability with respect to client's needs 1.11 demonstrates congruency in verbal communication (words, touch, facial expression, posture) 1.12 recognizes her own prejudices and handles them appropriately
Maintenance	2. assume responsibility for maintaining the helping relationship	2.1 encourages the client to express his beliefs, emotions and opinions 2.2 indicates her respect for the client's verbal expression or silence 2.3 refrains from making assumptions about the client's knowledge and values 2.4 initiates and stimulates in the mind of the client those insights that are important for his own health 2.5 recognizes the client's thresholds of tolerance 2.6 recognizes and deals with unintentional threat to the client 2.7 recognizes her own limitations and admits error 2.8 discriminates nursing actions that should be for or with the client
Termination	3. assume responsibility for terminating the helping relationship	3.1 reminds the client that the termination date is at hand 3.2 encourages the client's expression of emotion related to separation 3.3 recognizes and deals with her own emotions related to separation 3.4 reviews with the client accomplishment toward meeting mutual objectives 3.5 ensures that the termination of the relationship is complete and final





# PROJECT REPORT

## DRAFT STANDARDS FOR NURSING PRACTICE

### STANDARDS RELATED TO PROFESSIONAL RESPONSIBILITIES<sup>1</sup>

Criterion Variable	Nursing Standards	Nursing Behaviours
Legal responsibility	<i>Nursing practice requires the nurse to:</i> 1. <i>conform to statutes, policies, procedures and directives relevant to the practice setting</i>	<i>The Nurse:</i> 1.1 knows relevant legislation governing or affecting the profession 1.2 practices within the recognized scope of nursing as defined by a conceptual model for nursing and her interdependent and dependent functions 1.3 follows established legal procedures in the maintenance of records, obtaining consents, identification of clients, use of control drugs 1.4 reports unsafe practice or professional misconduct of other nursing personnel to appropriate authorities 1.5 knows the implications related to nurse registration/licensure
Ethical responsibility	2. <i>conform to the code of ethics of her profession</i>	2.1 protects the rights of the individual such as confidentiality, privacy, beliefs, values (cf. nursing process 1.6; helping relationship 1.8) 2.2 reports errors and omissions and takes appropriate action 2.3 recognizes own limitations and seeks appropriate resources 2.4 reports unsafe practices of other health care workers to appropriate persons 2.5 maintains an acceptable standard of nursing practice and professional behaviour as determined by national and provincial nursing associations and own setting
Administrative responsibility	3. <i>comply with administrative practices and procedures in a given setting</i>	3.1 follows established administrative policies and procedures. 3.2 uses appropriate channels of communication 3.3 guides and supervises auxiliary nursing personnel in accord with her job description and/or directives in her setting 3.4 recognizes health hazards in the work setting and takes appropriate action

1. Adapted from:  
Canadian Nurses Association *A Blueprint for a Comprehensive Examination for nurse Registration/Licensure* (Ottawa: May, 1977). pp. 4-5

#### Tell us what you think about these draft statements

- Philosophical statement about nursing
- Toward a definition of nursing practice
- Beliefs about national standards for nursing practice
- Standards related to a conceptual model for nursing
- Standards related to the nursing process
- Standards related to the helping relationship
- Standards related to professional responsibilities

Please write  
your comments  
and send to:

Patricia Wallace,  
Project Director,  
Canadian Nurses Association,  
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# Introducing New they stay twice

## Why It's Better for Baby

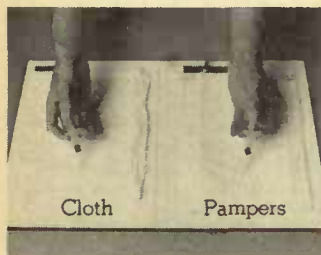
### 1. Softer surface next to baby's skin

- ☐ Embossed topsheet looks and feels softer...reduces skin contact and increases separation of skin from moisture in pad.

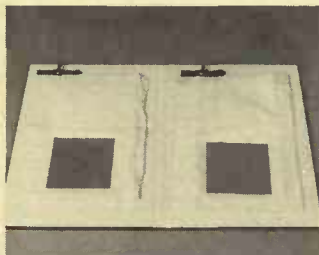
### 2. A drier, more comfortable baby

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- ☐ Stronger absorbent pad with stronger tissue envelope...provides 225 percent more wet strength for a 60 percent reduction in tearing and shredding.

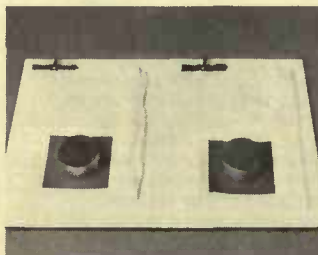
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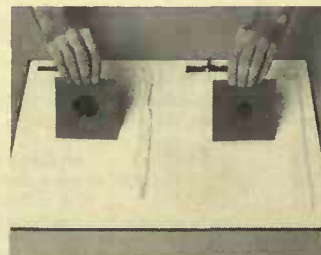
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Quilted Pampers is twice as dry as cloth



# Quilted Pampers— as dry as cloth



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# CNA Directors Approve Nursing Ethics Code, 1980 Budget and Health Services Brief

Approval of the first Canadian Code of Ethics for nurses — a person-oriented care ethic applicable to nursing service, education, administration and research — was at the top of the list of accomplishments of CNA directors at this year's Spring meeting.

The three-day, end of February meeting at CNA House in Ottawa also saw directors:

- officially endorse CNA's brief to the Health Services Review '79 dealing with ways of putting "health" into health care
- approve a \$3,275,093 budget for the national association for 1980
- finalize plans for the association's annual meeting and convention
- give the go-ahead to activities which will serve as preliminary steps to an accreditation project, and
- approve a position statement supporting the recommendation of the Canadian Law Reform Commission concerning the definition of death.

Numerous reports were received by directors during the course of the meeting, including those from:

- CNA's Nursing Research Committee
- the director of the association's Development of a Definition of Nursing Practice and Standards for Nursing Practice Project
- CNA's member-at-large for nursing education, Margaret McCrady, on the National Forum on Nursing Education in Ottawa last Fall, and
- Principal Nursing Officer Dr. Josephine Flaherty.

The Code of Ethics, a copy of which is contained in this issue of The Canadian Nurse, will be presented to nurses attending the annual meeting in Vancouver for endorsement by the association membership.

The Code, officially titled "CNA Code of Ethics: an ethical basis for nursing in Canada", is the result of almost two years of work by Sister Simone Roach of Antigonish, N.S. Sister Roach, who is on a study leave from her job as chairman of the nursing department of St. Francis Xavier University to act as project director, believes that: "At this point in our history, our credibility as a profession may very well depend on (1) the motivation and ability of individuals and the profession to make a person-oriented care ethic operational in nursing practice, education, administration and research and (2) the conviction with which we express this person-oriented care ethic in our codes of ethics."

The Code of Ethics grew out of a resolution approved by CNA membership at the annual meeting in Toronto in 1978. Sister Roach met with eminent specialists in bioethics, nursing and medicine at conferences and seminars in Canada and the United States during the period in which she was developing the Code.

The 1980 budget approved by directors puts CNA in the black again, with a predicted excess of revenue over expenditures of \$30,179. Membership fees are expected to reach just over \$2 million or \$2,039,215 in 1980, assuming the same level of membership as in the previous year. Other revenue, including subscriptions and advertising for The Canadian Nurse and L'infirmière canadienne, and CNATS examination fees is estimated at \$1,972,926. (For more information see "Where does my money go?" and "Who pays what?")

The final draft of the report on the Development of a Definition of Nursing Practice and Standards for Nursing Practice will be in the hands of CNA directors on schedule in June, according to project director Pat Wallace, who has been working with a task group on the project. Directors also approved a second, "interpretation phase" of the project to follow release of the final documents. (See also page 11 of this issue.)

Two CNA position statements were approved by directors during the course of the meeting. The first, a re-affirmation of the association's belief that "the delivery of nursing care is the social and professional responsibility of nurses", states:

*"Some hospital administrations have employed persons other than nurses to direct nursing services. Although this situation occurs infrequently, CNA has decided to take a position on the issue because of the seriousness and the consequences of such a move.*

*The CNA affirms that:*

1. *Nursing services must be administered by a director who has the responsibility to ensure the quality of nursing care and the provision of it in a quantity sufficient to respond to the needs of clients.*
2. *The director must have educational preparation in nursing and in administration.*
3. *The person occupying the position of director must report directly to the executive director and must therefore be at the top policy making, level of the organizational structure."*

The second CNA position statement approved by directors reads as follows:

*The Canadian Nurses Association supports the recommendations of the Law Reform Commission to Parliament regarding proposed changes in the legislation on the definition of death. The Canadian Nurses Association believes that this legislation should be adopted as a safeguard to the quality of health care in Canada. The Association recognizes that difficulties arise in the clinical area as a result of inadequacies in the present legislation. There is evidence that some health professionals, for fear of legal consequences, are reluctant to stop aggressive treatment for the person with irreversible cessation of all brain function. The impact of continuing life-support measures in such circumstances may be profound for family members, for persons such as nurses who provide direct care to the patient, and for other citizens with potentially reversible conditions who require the sophisticated technology and health services being used for the brain damaged person. The Canadian Nurses Association believes that this current state of affairs is undesirable for both its members, and for members of the public. The proposed legislation will facilitate clinical decision making and thereby promote long term benefits both for providers and consumers of health care.*

## WHO PAYS WHAT? CNA membership fee revenue, 1979

Prov./Terr.	Membership	Total paid	Per capita fee
		\$	\$
RNABC	18,561	312,448	16.83
AARN	14,641	257,913	17.61
SRNA	7,656	132,183	17.26
MARN	7,748	133,839	17.27
RNAO	15,125	266,063	17.50
OIIQ	46,868	570,384	12.17
NBARN	5,151	87,093	16.90
RNANS	6,929	119,097	17.19
ANPEI	971	11,983	12.34
ARNN	3,884	64,287	16.55
NWTRNA	212	1,908	9.00
	127,746	1,957,198	15.32
	Late fees paid	198	
	Affiliate fees	150	
	<b>Total</b>	<b>1,957,546</b>	<b>15.32</b>



## WHERE DOES MY MONEY GO?

### CNA membership fee expenditure and members' equity, 1979

	Total fees	% of total	Per member
Boards & committees	\$ 172,253	8.80	\$ 1.35
Special projects	169,642	8.67	1.33
Labour relations	139,401	7.12	1.09
Affiliation & sponsorship	282,280	14.42	2.21
Library	161,560	8.25	1.26
CNA Testing Service	108,537	5.54	.85
Public relations	84,871	4.34	.66
The Canadian Nurse	385,835	19.72	3.02
L'infirmière canadienne	374,133	19.11	2.93
Member Equity			
House Expansion \$50,000			
Surplus 29,034	79,034	4.03	.62
<b>Total</b>	<b>\$ 1,957,546</b>	<b>100.00%</b>	<b>\$ 15.32*</b>

\*Though the unit fee per individual CNA member was \$18.00 in 1979, the total fee revenue received from 127,746 CNA members at December 31, 1979 (based on information provided January 1980) was \$1,957,546 or a per capita fee of \$15.32. Fees paid on behalf of individual provincial members ranged from \$17.61 to \$9.00.

## CNA directors approve seven resolutions for presentation at annual meeting

Voting delegates attending the CNA annual meeting and convention will be called upon to consider the following resolutions approved by directors of the association at their March meeting for presentation at the 1980 meeting.

### CERTIFICATION

1. Whereas, the American Nurses Association has developed and adopted an ANA certification to recognize excellence in the practice of nursing administration, and such certification is available to qualified nurse administrators by means of examinations;

Resolved, that the Canadian Nurses Association discuss with the American Nurses Association the feasibility of making this certificate examination available to Canadian nurse administrators, or in lieu of this that the Canadian Nurses Association investigate and develop a comparable tool for Canadian nurses.

### CONTINUING EDUCATION

2. Resolved, that the Board of Directors of the Canadian Nurses Association study the issues inherent in continuing education for nurses and produce a position paper on continuing education for registered nurses in Canada during the 1980-82 biennium.

### INCOME TAX

3. Whereas, the person who works in the home may wish to augment his/her skills by attending courses offered in publicly funded institutions of learning;

Whereas, the competence of each spouse should be maintained in a healthy, informed family life; and

Whereas, the Income Tax Act encourages one spouse to improve his/her knowledge through provision of an income tax deduction for course fees, while not providing the same privilege for the other;

Resolved, that the Canadian Nurses Association support the National Council of Women of Canada in their request to the Government of Canada to amend the Income Tax Act to provide income tax deduction to wage earners for monies expended on such continuing education courses for their non-earning spouses.

### ADMINISTRATION

4. Resolved, that the Canadian Nurses Association publicly re-affirm its belief that the executive responsible for the Department of Nursing shall be an educationally qualified registered nurse who shall be a member of the senior hospital administrative staff, reporting directly to the chief executive officer; and further be it

Resolved, that the Canadian Nurses Association request the Canadian Council on Hospital Accreditation to enforce the above standard which is stated in Standard Number Two under Nursing Services section of the Guide to Hospital Accreditation 1977, as a basis for accreditation of nursing departments.

### BACCALAUREATE DEGREE

5. Resolved, that the Canadian Nurses Association establish as a priority for the next biennium, the development of a statement concerning the baccalaureate degree in nursing as the minimal educational requirement for the practice of professional nursing in Canada.

### SPECIALIZATION

6. Whereas, the practice of nursing has become greatly diversified and the level of knowledge and skill required in various specialty areas of nursing practice is increasing rapidly;

Whereas, it is improbable that students in nursing programs will receive theoretical and clinical content in specialized practice areas; and

Whereas, Canadian nurses are beginning to write the examinations for certification in nursing specialties developed by the American Nurses Association in increasing numbers;

Resolved, that the CNA Board of Directors study the feasibility of developing examinations for certification in major nursing specialties.

### INDEPENDENT PRACTITIONERS

7. Whereas, professional nurses are becoming more involved in independent health promotion activities and are providing care to clients as independent practitioners in a variety of settings;

Resolved, that the CNA go on record as favoring the concept that independent nursing services provided to clients by professional nurses be eligible for compensatory coverage in provincial health care plans.





## Putting "health" into health care, CNA brief promotes more use of nurses

"A strategy to achieve the next level of wellness for Canadians," is the description CNA gives to the recommendations contained in its brief to Health Services Review '79, presented to former Supreme Court Justice Emmett Hall in Ottawa on March 4th. Speaking on behalf of the nurses of Canada, association spokesmen advocated the development of a health care system that would allow the initiation of more programs promoting primary health care, new points of entry into the system and more efficient use of all qualified health personnel.

"Nurses, who comprise two thirds of the health occupations, declare with confidence that they are capable of demonstrating their abilities to make major contributions to the development of the system in a variety of ways: store-front health counseling clinics, nurse practitioners in medical clinics, increased public health services and programs, community health centres, clinical nurse specialists in hospitals to do special teaching, follow-up programs in the home, through greater coordination and care by nurses in home situations."



The eight recommendations contained in the brief are as follows:

### Recommendation 1

*That the existing legislation underlying the hospital and medical insurance programs be revised to allow the emergence of a health insurance program which would stimulate the development of primary health care services, permit the introduction of new entry points and promote the appropriate utilization of qualified health personnel.*

The promotion of the appropriate utilization of qualified health personnel will require other legislative revisions to enable nurses and other prepared health personnel to undertake activities which currently are legally defined as the exclusive domain of medicine.

### Recommendation 2

*That provincial legislation be revised to enable qualified nurses and other prepared health personnel to undertake activities currently defined as medical acts.*

The immediate corollary to the foregoing recommendations is the need to institute a mechanism for remunerating all health personnel by salary. This submission illustrates how the fee-for-service payment scheme for physicians, together with their guardian role of the gates of the system, cannot but increase the use of costly acute care services, whether necessary or not.

### Recommendation 3

*That remuneration of all health personnel be by salary.*

Concrete examples are used to demonstrate the need to overcome the complexities and frustrations confronting the users of the system. New points of entry, as recommended by CNA, refer to the recognition of innovative uses of existing facilities and organizations, rather than the building of costly new structures.

### Recommendation 4

*That Health Services Review '79 strongly support the initiation of better preventive, diagnostic and ambulatory care programs through various community-based points of entry.*

The basic principles of the Charter of Health are the uniting force which transforms ten provincial systems of health care into a national system. It is essential that criteria be developed by the federal and provincial governments, in concert with non-governmental organizations to ensure that these principles are honored.

### Recommendation 5

*That the federal and provincial governments, together with relevant non-governmental organizations, develop criteria to ensure that the underlying principles of the Canadian health insurance system are being upheld.*

A basic requisite to the preceding recommended changes is the need for health research and its fruit, data on the health status of Canadians and the health care system.

### Recommendation 6

*That a health sciences research council be established to focus on the study of health services, the system of delivery and its effectiveness.*

### Recommendation 7

*That the federal government be requested to reinstitute a national health survey which would provide the necessary information upon which to build and evaluate a health care system to meet the needs of the people.*

Canadian consumers are becoming increasingly knowledgeable and articulate regarding their purchase of goods and services. These consumers should be as knowledgeable about the types of health professionals, the cost of the services and the sources of care, as they are about the ingredients, cost and metric containers of peanut butter.

### Recommendation 8

*That all governments and health profession organizations be urged by Health Services Review '79 to adopt, as a priority, better and broader health education programs to sensitize consumers to the cost of acute care services.* ♣



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### Adverse effects

...on hypersensitive individuals<sup>3,4</sup>

...on the gastrointestinal tract<sup>7,8</sup>

...during pregnancy<sup>9-11</sup>

...of concomitant use with other drugs<sup>2b</sup>

...on the blood<sup>5,6</sup>

...resulting in iron-deficiency anemia<sup>5,12</sup>

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# news

## Fun and fitness featured at orthopedic nurses' meeting

"Canadians must be taught what fitness is, how to get fit and how to stay fit," says former Olympic contender Abby Hoffman, supervisor of Sports Services with the Ministry of Culture and Recreation of Ontario. Hoffman, who was guest speaker at the recent third annual conference of the Canadian Orthopedic Nurses Association, believes that Canadians generally lead inactive lives and that, to date, our approach to changing this has not been effective.

Children attending physical fitness classes, Hoffman says, are taught specialized skills, such as shooting baskets, which they will never be able to use again. The aerobic aspect of fitness is only just beginning to be recognized: many of our male population still feel they are staying in shape if they participate in short season, non-aerobic sports such as baseball, football and hockey. Even elite athletes sustain fewer injuries if they maintain good basic fitness levels.

Hoffman was one of 25 speakers featured at the 3-day CONA conference which took place in Toronto. A total of more than 600 nurses from across Canada and the United States were in attendance. In addition to the papers and business sessions, nurses were also given the opportunity to tour three large orthopedic facilities in the Metro area.

Two Montreal nurses were signalled out for special recognition during the meeting: Orthopedic Nurse of the Year, an award sponsored by Dillon Company, went to Doreen Morin of St. Mary's Hospital. Mary Flannery of the Montreal Children's Hospital received the Dupuis Award for Continuing Education for her contribution to continuing education in the orthopedic nursing field.

The CONA journal, now in its second year of publication, with a circulation of more than 800 CONA members, is currently sponsoring a writing contest to encourage members to contribute to their journal.

For more information on the Canadian Orthopedic Nurses Association, contact: CONA, 43 Wellesley Street East, Toronto, Ont. M4Y 1H1.

## CAUSN registration over the 100 mark

Ann Hilton

Accountability in nursing education was the theme of the Western Region Canadian Association of University Schools of Nursing conference. "We are accountable to only two groups: the public and the profession of nursing, which gives us a mandate and invests in us its trust to prepare those who will be the nurses of tomorrow and future leaders of nursing," Dr. Dorothy Kergin, director of the University of Victoria School of Nursing remarked in her keynote address.

"We are not accountable to students nor to future employers but we are responsible for providing students with the opportunity to develop the skills and abilities to practice competently as professional nurses. These skills provide them with the reasonable expectation of employment and we must describe the abilities of the graduates so that employers may decide whether or not to employ them."

Speakers taking part in a panel discussion focused on who really is accountable for what. Dr. Bud Phillips from the Vancouver School of Theology explored differences between responsibility and accountability; Maureen Creed, a fourth-year student at U.B.C., gave examples of how we must be accountable for our own actions from the viewpoint of the practitioner.

"Hospitals must provide the climate, facilities and role models for appropriate learning," said Roselyn Smith, director of nursing at Children's Hospital. Ann Taylor, director of nursing, Metropolitan Health Services, stressed outcome-oriented management and emphasized priority determination. Dr. Marilyn Willman, director of U.B.C. School of Nursing, posed the question of nursing educator's accountability. Anne Wyness from U.B.C. chaired the panel.

Sue Rothwell, director of nursing at the Cancer Control Agency with a dual appointment at U.B.C., former president of RNABC, chose the topic of "Political Accountability in Nursing Education", for her luncheon address.

"The first step in our responsibility is to shake off our naive beliefs about health care as an inalienable right," she said. "Health care is alleged to be a right of Canadians, but how it will actually be provided is determined more by a politician's need for votes than by rational process. The political questions of regulation of professionals and, to a large extent, long range policy planning are overshadowed by the economic considerations of cost. The larger the cost, the hotter the political interest becomes."

"It is not enough that we teach students the right values and the proper way to nurse, and then excuse our colleagues in health agencies for their poor performance. For our political accountability we need to be in there beside our colleagues and our students, changing what is wrong. If we merely excuse it, we perpetuate the uncritical thinking and acting that leads to divisiveness among us."

Other speakers included: Kay Arpin, University of Toronto, "Joint Appointments: Strengthening the Clinical Practice Component in Nursing Education Program"; Omaira Mansi, McGill University, "Our Graduates will be Accountable for Their Nursing Practice: A Promise Declared to Our Profession and to the Public and a Commitment Made to Our Students"; Ann Murphy, U.B.C., "Personal Accountability as the Core of Professional Accountability"; and Ina Watson, University of Saskatchewan, "Socialization of the Nursing Student in the Professional Nursing Education Program."

More than 100 registrants attended the conference, the largest in the association's history.

## Reminders for Vancouver!

A short list to help you plan for the best possible time:

- **Post convention tours:**  
Local — A variety to choose from: Harbour Centre and Gastown; city tour with dinner, Grouse Mountain tour with dinner, etc. Register now or after arrival.  
  
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Vancouver, B.C. V6C 1B6
- **Special Breakfasts** each day; tickets at the hospitality desk.
- **Luncheons** — June 22, 24 and 25; hosted by the planning committee and RNABC; tickets at the hospitality desk.
- **A bus to Stanley Park** for early morning joggers; sign up at tour desk.



## Nutritionists share findings on diet and health

What kind of society dooms its children to preventable illness such as coronary disease, hyperlipidemia, hypertension and obesity? Why are the dietary habits of our teenagers, especially 16-17 year old females, inadequate to ensure optimum health? These were some of the questions raised at a two-day Kellogg Salada Nutrition Symposium attended by more than 300 nutritionists, medical personnel, journalists and others in Toronto in mid-March. The latest information on the relationship between nutrition, lifestyle and health included reports on:

- a 1978 nutrient intake study of nearly 400 Ontario school children by Dr. Harvey Anderson, University of Toronto and Dr. Anthony Hargreaves, Harvard University indicating that, as children grow older, more non-traditional foods are included in their diets and the total nutritional quality of most frequently consumed foods decreases. In all age groups, rural children drank less orange juice and took fewer vitamin supplements than their urban counterparts. Of greatest concern were the dietary habits of teenagers, particularly the 16-17 year old females, who seem to need aggressive nutrition education programs.

- hospital malnutrition, assessed as affecting between 40 and 50 per cent of patients in one general city hospital. Dr. G. Blackburn, Harvard Medical School, reported that he has found low nutritional status to be associated with anergy (a lack of response to an injected allergen or antigen) which is in turn associated with an increased frequency of sepsis and mortality. If this anergic state is due to malnutrition, it may be reversed within three weeks if the nutritional state is improved. Individuals must receive protein every day as depletion occurs rapidly if daily requirements are not met but, with the availability of protein enriched glucose solutions, it is no longer necessary to maintain patients on plain glucose for days at a time. On the other hand, when total parenteral nutrition is used, only 2000-2500 calories should be given, as more is not necessarily better.

Studies have now been completed showing nutrition as the major contributing factor in complications leading to the use of respiratory and intensive care units. Dr. Blackburn feels that biometric assessments or nutritional screening on an outpatient basis of all individuals scheduled for surgery would allow recognition of those at high risk for protein-calorie malnutrition.

- myths of diet and cancer and new areas of concern. To date researchers have been unable to demonstrate any increased risk of bladder cancer with the use of artificial sweeteners, while alcohol has been found to effect an increased incidence of oral, esophageal and laryngeal cancer when taken in amounts comparable to seven shots of whiskey daily.

"Cardiac disease and cancer are not necessarily problems of old age" stated Dr. Ernst Wynder, President, American Health Foundation. "Most human cancers are related to man's lifestyle, especially in terms of what he smokes, eats and drinks." In fact, one-half of all cancers experienced by women

relate to dietary factors as do one-third of all cancers experienced by men. In North America, one person in 15 can expect to develop cancer of the colon during their lifetime. While there seems to be no relationship between this type of cancer and constipation, there does seem to be a relationship to a high fat diet. Similarly, a high fat diet, either saturated or unsaturated, seems to be related to cancer of the breast which affects one in 13 women. Obesity is no longer considered to have any relationship to this condition.

Dr. Wynder did have some positive suggestions: no one should drink whole milk (including infants after weaning from breast milk), follow a prudent diet in which fat intake does not exceed 35 per cent of total

calorie intake and cholesterol intake does not exceed 300 mgm per day.

- the effects of diet on atherosclerotic heart disease. Dr. Kritchevsky of the Wistar Institute of Anatomy and Biology, Philadelphia, stated that everything in our diet affects the serum cholesterol, not just our cholesterol intake. However, it would seem that high levels of serum high-density lipoprotein (HDL) does decrease the tendency to ASHD. Jogging and a moderate consumption of alcohol have been shown to raise these HDL levels which are normally higher in women than men. Certain types of fiber such as pectin have also been shown to be effective in lowering cholesterol levels while bran has not been shown to have any effect on serum cholesterol levels. ♣

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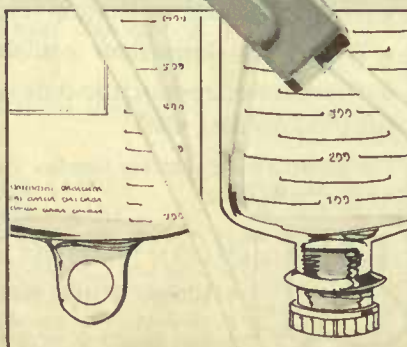
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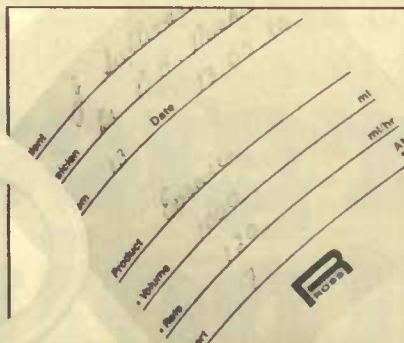
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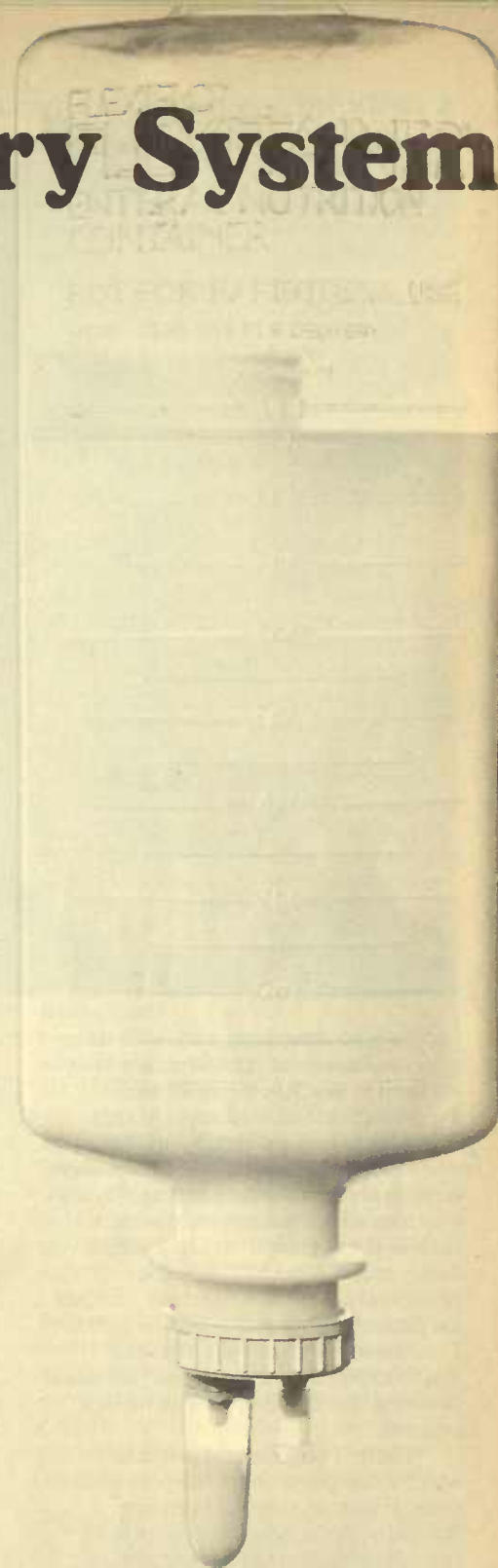
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A plastic surgery technique offers a way for patients with port wine stains to alter their appearance.



Photos courtesy of Toronto General Hospital

Capillary hemangioma, port wine stain or *nevus flammeus* are all terms which are used to describe a condition of over-vascularization of areas of skin. Port wine stains are usually full-blown when they appear at birth, and are often seen on areas of the face and neck; they may also affect mucous membranes, such as the conjunctiva. The color, a dusky red, is often intensified in emotional upset or on exertion, or when the patient is exposed to heat or cold. Treatment in the past has involved ionizing radiation, freezing and the use of covering skin creams, all with limited success.

There is one surgical procedure which attempts to cover the port wine stain, known as surgical tattooing. Basically, the surgeon tries to place enough skin-colored pigment in the superficial dermis so that the stain is markedly reduced and that the tattooed area blends into the surrounding skin.

Although stains may be found anywhere on the body, the procedure is reserved for facial areas for both technical and psychological reasons. The tattooing technique may be used also to 'tone down' hyperpigmented skin grafts, and for vitiligo which is an absence of pigment in the skin, but the results here are not consistently good.

Several factors dictate that a perfect color match can never be achieved in tattooing: artificial material is being used in living skin and the patient's skin changes color with the seasons, with the health of the patient and with his moods; therefore, surgical tattooing attempts only to give an average color which will lessen the noticeability of the birthmark.

May Chung Julie McKenzie

#### Pre-operative preparation

Surgeon Dr. Robert A. Newton of Toronto is currently the only surgeon in Canada who does this procedure. Patients, after initial consultation with the doctor, are sent to the Hospital for Sick Children in Toronto, to the Department of Visual Education for pigment assessment. Several color photos using a standard 35 mm camera are taken, and a medical artist measures the patient's normal skin pigmentation with a densichron. A computer is then used to give the proper mixture of pigments to closely match the patient's normal skin color. No tattooing or color matching is done during the summer months. Depending on how well the pigment is retained after surgery, the procedure may be repeated using the specially-formulated pigment two or three times at six month to one year intervals.

# Surgical Tattooing



### Operative procedure

The patient's skin is prepared as for other types of surgery; we do not shave but wash the area with chlorhexidine gluconate 0.5% aqueous solution. The size, location and time estimated to cover the stain determine the type of anesthetic to be given. However, even when a general anesthetic is used, Xylocaine® 1% with epinephrine is injected locally to stimulate vasoconstriction and to decrease bleeding which would dilute the pigment.

The machine used in the tattooing process is turbine-driven and injects pigment into the skin with small sharp pointed needles 0.05 mm in diameter at 20,000 penetrations per minute. The needle penetration is 2 to 3 mm, depending on the area being treated. Most of the face is treated at 2 mm while the eyelids are penetrated only to a depth of 1 mm. While the doctor is using these multiple sharp needles at ultra high speed, the handpiece of the instrument must be kept moving constantly to avoid severely traumatizing the skin.

The pigment is kept at toothpaste consistency, and particles are struck into the skin at every stroke of the needles. A needle tip cautery is used after the tattooing to destroy those obvious blood vessels close to the surface which cannot be masked by the pigment layer.

Following the tattooing, the skin is covered with more pigment, and Polysporin® ointment. The operative site is then covered with Telfa® gauze cut to size and taped over the skin if the area is small and the patient is an outpatient. Inpatients' skin remains undressed, and they are removed from the O.R. to the recovery room, and then to the plastic surgery unit.

Crusting forms on the skin which peels off in 5 to 7 days; the pigmented area may look flat and stark in color but within a few weeks post-op the tattooed area begins to blend into the adjacent normal-colored skin as the pigment disappears both internally and externally.

The recent introduction of the argon laser in treatment of port wine stains suggests that in the future, perhaps, patients may be treated with a combination of the laser cautery and the surgical tattooing procedure.

### CASE STUDY

#### A new face

In the early part of 1979, Mrs. C. entered Toronto General Hospital's plastic surgery unit to have elective cosmetic surgery which would alter her facial appearance. From birth, she had borne a disfiguring burgundy-colored capillary hemangioma, which covered the majority of her face and part of her neck.

The 30-year-old married woman and mother of one child had a job as a clerk typist near her home in Mississauga, Ontario; she told nurses that although she had always been aware of her "mark" it had never truly bothered her.

When she was quite young her parents had wanted to have the birthmark surgically removed but when they were warned that significant scarring was a possible side effect, they decided against treatment at that time.

In her job as a secretary, Mrs. C. met the public face to face each day, but found her mark to be of little significance in her personal life. She was actively involved in community activities, and was pursuing her Business Administration degree at night school.

In 1978, Mrs. C. read a news item in a magazine about Dr. Newton's procedure and she thought about the possibility of having her port wine stain removed. The idea of surgery without scarring appealed to her and she contacted Dr. Newton for a consultation; she decided to have the surgery.

Mrs. C. was admitted to hospital the night before her surgery. Her past medical history was uneventful: she had had a tonsillectomy in 1958, an appendectomy in 1969, and had given birth to a child in 1970. She was a non-smoker, and had no known allergies.

The usual admission blood work was done (Hgb, Hct, and WBC), and routine urine testing, and she was seen by the anesthetist who ordered pre-operative sedation to be given in the morning. The nurse assigned to Mrs. C. spent time with her patient to give pre-operative instruction. Mrs. C. was told that she would not be able to eat or drink after midnight, and deep breathing and coughing routines were demonstrated to her along with the explanation of the effect of a general anesthetic on the respiratory system.

The most important aspect for nurses in dealing with any patient who is having surgical tattooing done is to recognize the fact that although the procedure is an elective one, any patient experiences a fair amount of anxiety and apprehension. Facial appearance and resulting self-image will undergo a change, and the nurses must understand that patients having this type of plastic surgery will have certain emotional needs.

For this reason, then, Mrs. C. was prepared for her post-operative appearance. She was told that the pigment would cake and that there would be 'scab' or crust formation over the affected area of skin. No dressing would be applied but she would have Polysporin® ointment on her face to act both as an antibiotic and a skin moisturizer.

Mrs. C. returned to the ward the same day after her surgery from the Recovery Room, with orders to have sips of fluids progressing to diet as tolerated and analgesia q4h p.r.n. The head of her bed was to be elevated 30 to 45 degrees to minimize facial swelling. Polysporin® ointment was to be re-applied to the skin daily and Mrs. C.'s face was not to be washed with soap and water for five to seven days. Because of the possibility of infection, her hair was kept tied back from her face.

It has been noted that a common reaction post-operatively with this procedure is disappointment. We had to reassure Mrs. C. daily that the unattractive scabby, oozing appearance of her face was temporary, and that in 10 days to two weeks her face would have healed enough for her to apply a light cover of make-up if she felt it necessary. Mrs. C. recovered well post-op and was discharged five days after surgery, with an appointment to return to Dr. Newton's office.

In a follow-up nursing interview, Mrs. C. was asked how she felt about the results of her surgery. In spite of the fact that before surgery she had said her mark never bothered her much, her comment was that she had increased self-confidence and generally felt better about herself than she had before. ♡

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*May Chung, RN, is a graduate of the Toronto General Hospital. She has worked in the operating theaters of this hospital since graduation and has specialized in plastic surgery over the past three years.*

*Julie A. McKenzie, RN, a graduate of George Brown College, Toronto, was a staff nurse working in plastic surgery, burns and microvascular surgery at the Toronto General Hospital at the time of preparing this article. She has recently taken up residence in London, Ontario.*





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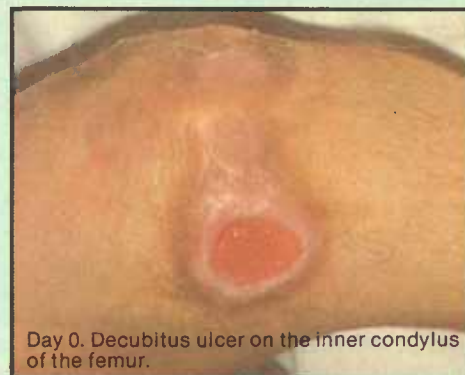


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**Day 3.** Conventional dressing changed twice.



**Day 4.** Conventional dressing changed twice.



**Day 5.** Conventional dressing changed twice.



**Day 6.** Conventional dressing changed twice.



**Day 7.** Conventional dressing changed twice.



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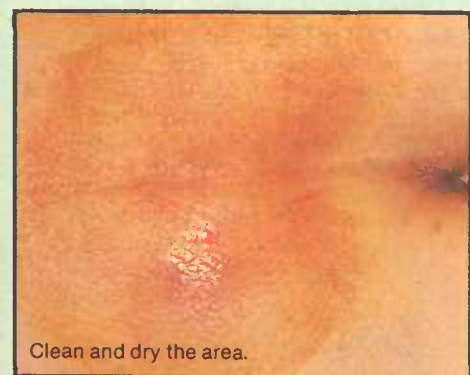
## Easy to apply, easy to remove

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week and then removed painlessly, without damaging healing tissue.

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**Clean and dry the area.**



**Apply Op-Site.**

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Erythema generally disappears within a few days, provided that the patient is turned regularly and often. But you can still use Op-Site for extra protection, as long as there is risk of skin irritation.

1. Winter, G.D.: Healing of Skin Wounds and the Influence of Dressings on the Repair Process—Surgical Dressings and Wound Healing, Harkiss, K.J. (Ed.), Bradford University Press, 1971.

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# The need to know?

If a woman of 34 is refused amniocentesis and subsequently bears a child with Down's syndrome, can she sue those who refused the diagnostic procedure?

Is a doctor negligent if he or she does not tell a patient about genetic counselling services? What if such counselling is indicated, but the patient can't afford to travel to the nearest clinic? How will this affect her peace of mind?

Should amniocentesis be performed on women who are not prepared to consider abortion? How will she react to the news that the baby she's carrying has an untreatable and/or fatal genetic disease?

Should prospective parents be told the sex of their child? Should abortion be permissible only if there is fear of a sexlinked disease, but not just because the parents want a child of a certain sex?

Should widespread screening for carriers of genetic diseases be done? What is the psychological impact on those diagnosed as carriers?

How should society weigh the various costs associated with genetic disease—for example, the costs of amniocentesis and abortion versus those of maintaining children born with genetic defects?

As the technology necessary for genetic screening and prenatal diagnosis moves out of the research lab and into the clinic, a welter of social, political, legal and economic issues confront us — difficult issues that involve balancing the rights and responsibilities of society (and its subgroups, such as doctors and lawyers) against those of the individual. The questions cut to the most emotional level: how much reproductive freedom can people have; what are the limits of personal choice; who bears the costs of genetic disease; who makes the value judgments?

As it becomes clearer what *can* be done, the problem of what *should* be done looms large. "It is distressing that many of these questions are not simply unanswered in Canada, but unasked," writes Bernard Dickens in the *Canadian Family Physician*. Dickens teaches medical jurisprudence at the University of Toronto.

These and other questions were raised at a workshop on social issues and human genetics sponsored by the Science Council as part of an on-going study on Science and the Legal Process. The meeting was attended by experts in genetics, medicine, law and ethics, many of them directly involved in genetic counseling and screening programs.

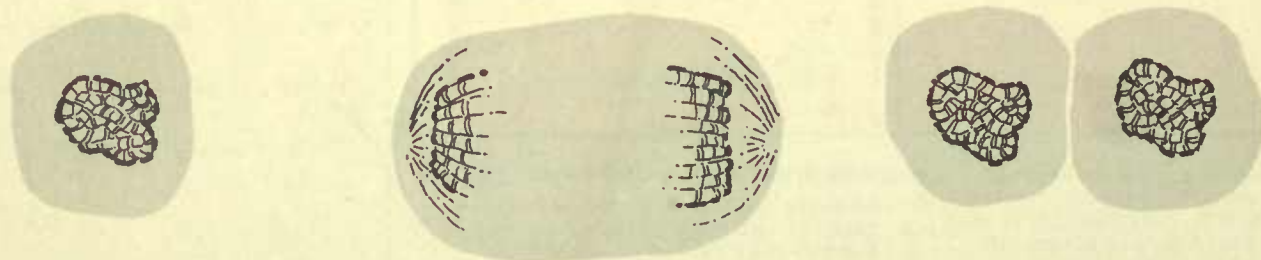
There are 15 prenatal diagnosis centres in Canada. Ontario has the greatest number with five (Toronto, Ottawa, Hamilton, London and Kingston). Quebec, Alberta and British Columbia have two each; and Saskatchewan, Manitoba, Newfoundland and Nova Scotia have one each. The services and personnel available vary from centre to centre. (Canada has between one and two trained geneticists per one million population; the World Health

Organization recommends five per million.)

All centres offer prenatal diagnosis to mothers who have previously borne a genetically abnormal child. Most also offer the service to those with a family history of certain genetic diseases. Generally, women 35 or older are accepted at most of the clinics (two set higher minimum ages—37 and 38) but the majority indicated they are flexible on age and will take somewhat younger women. Although only about 10 per cent of pregnant women are over 35, they bear more than a quarter of Down's syndrome babies. The risks rise sharply with age, from less than 1 in 1000 births for women under 30, to 1 in 500 at about age 35, 1 in 100 at age 40, and 1 in 40 at 45 and over.

About three to five per cent of infants born each year have congenital malformations, abnormal chromosomes or genetic disorders. Genetic diseases account for about 20 per cent of infant deaths in Canada, and about half of spontaneous miscarriages are associated with such conditions. The number of disorders that can be detected through prenatal diagnosis has increased steadily in recent years (more than 60 biochemical abnormalities can be detected by examining fetal cells), but undergoing amniocentesis is no guarantee that a normal child will be born, because there are many disorders for which there are no tests and only indicated tests are made on any amniotic fluid sample.

The ability to detect an increasing number of genetic abnormalities raises a number of philosophical and moral questions, however. As one participant at the Science Council workshop put it: "Which defects are tolerable and





which are unbearable?" Should abortion be considered in the case of some defects, while others are not serious enough to merit publicly-funded abortions? Who decides what is tolerable or not tolerable?

In some cases, the alternatives are more clear-cut, if not necessarily any easier to accept, than in others. The effects of Tay-Sachs disease or of spina bifida, for example, are devastating and in the case of the former invariably fatal. But what of Down's syndrome, which can result in severe mental retardation? What about cleft lip or cleft palate? Hemophilia?

What's to be done when the amniocentesis turns up a case of mosaicism (some normal cells, some abnormal ones) or of abnormal sex chromosomes. The XYY chromosome pattern in males has received a notorious reputation for being associated with violent and anti-social behavior but, according to a background paper prepared for the workshop, several studies indicate there is little, if any, effect on physical and mental development or on behavior. As Dickens noted in his article: "The prediction of tendencies to behavioral maladjustment in the XYY male can become a self-fulfilling prophesy when parents, believing their growing child has violent traits, respond abnormally to his normally childish conduct.

The sex of the fetus can be determined from amniocentesis and this information has relevance when there is fear of a sex-linked disease such as hemophilia and Duchenne muscular dystrophy, both of which affect only males, although the mother is the carrier. Writing in *Science* magazine, a US doctor, Gilbert Omenn, noted: "Often the mother has grown up caring for a brother who succumbed to hemophilia or muscular dystrophy. The young woman presents a plaintive plea that she would not risk a pregnancy, let alone a delivery, if there were any chance that her own son would have the very same disease." Now she can have amniocentesis with the intention of carrying through the pregnancy only if the fetus is female.

Geneticists are generally negative to the idea of using prenatal diagnostic techniques simply to allow parents to choose the sex of their child ("just so they know what color to paint the room," as one participant at the workshop put it.) According to geneticist Tabitha Powledge, writing in the *New Scientist* magazine, many US diagnosticians "have been known to indignantly refuse (sic) requests for sex detection, although they have

sometimes been deceived into it by couples pretending to be at risk for a child with a sex-linked disease."

In the past, the argument has been that sex detection alone did not warrant the risk of the procedure, but since the risks have been reduced, will this argument hold sway with parents who really want a child of a given sex? This possibility raises the troubling issue of abortion based on sex alone. According to Powledge, this occurs in China where "providing parents with a child of the preferred sex is regarded as a way to reduce family size, an urgent priority... In the Chinese case, 29 out of the detected 46 female fetuses were aborted. Out of 53 detected males, only one was aborted."

She asks: "Is this a morally acceptable use of prenatal diagnosis? For the Chinese, who view population pressures as a matter of critical concern, the answer is clearly yes. In the West, where population pressures are considerably less, we are not so sure."

In fact, the relationship of abortion to prenatal diagnosis is one of the most problematical aspects of the issue. It would be different if the fetus could be treated for the disease while still in the womb; but, according to Omenn, there has been only one notable success in this field.\* Although many hope abortion will not prove to be the only solution, experts are not predicting any near-term alternatives. One such expert, Carlo Valenti of the Downstate Medical Center, New York, wrote in *Lancet* that "the chances that useful treatment will soon be at hand are slim. For many conditions, irreversible anatomical changes are probably present so early in gestation that their prevention or reversal (in the womb) by drug or enzyme treatment seems highly improbable...Although I would welcome an alternative to the abortion of a defective fetus, I reluctantly conclude that abortion must remain the solution to inheritable diseases."

If so, logically a number of questions follow: Should a woman whose moral convictions make abortion unacceptable be offered amniocentesis at public expense? Should women be required to agree in advance to an abortion, if indicated? A participant at the workshop said there is at least one case in Canada where this is done. Another said that it is "my impression that there is strong, if indirect, pressure to agree in some form to abortion. The attitude is that they don't like to go

\*Large doses of oral Vitamin B12 allowed normal development of a child affected by a biochemical defect.

through the trouble unless the woman is prepared to 'do something about it'."

However, the propriety of such an attitude was questioned, since the condition of the fetus is not legal grounds for an abortion. Canadian law allows termination of pregnancy only when its continuation would or would be likely to endanger the mother's life or health. If the prospect of bearing and caring for a genetically defective child would endanger her mental health, the pregnancy could be lawfully terminated. But if she decides that she will not abort the child regardless of the outcome, should she be refused amniocentesis?

Finally, who is to decide which defects warrant abortion? As Powledge notes: "Should one abort for Turner's syndrome,...where the chief disability appears to be sterility? The metabolic disorder galactosaemia, which results in cataracts and mental retardation, can be diagnosed before birth, but it can also be treated immediately after birth relatively simply by eliminating milk from the diet. Does the fact that therapy is available mean that one should not abort for such a disorder?" Moreover, should anyone impose limits on the point at which abortion is legal and acceptable?

Participants at the workshop suggested that there is a need for more research into the psychological effects of having to make decisions such as these, and of having to live with the consequences. What happens to the woman who refuses amniocentesis because she won't have an abortion, then bears an affected child? Do women feel pressured to agree to abortion — and made to feel socially irresponsible if they decide to bear defective children? Do they fully understand what they're getting into? As one workshop speaker noted, when widespread screening procedures become routine, "we run a very serious risk of providing couples with answers for which they had no question. Couples having very strong objections to abortion for any reason may, in the fact of...a test they did not request or fully understand in the first place, submit to abortion and bear the psychological consequences for as yet unknown periods. Abortion of a normal fetus as the result of a false positive result is a disaster that needs no further comment."

Diagnostic errors or testing inadequacies of various sorts can precipitate many such psychological crises. One US study reported the cases of two women who bore Down's syndrome babies after the fetuses were diagnosed as normal. Powledge painted



another hair-raising scenario arising out of an inconclusive first amniocentesis: "It seems almost inevitable that some day soon a second (amniocentesis) will result in a positive diagnosis, but that the ensuing late abortion will lead to a live delivery. Then, partly because of the availability of neonatal intensive care technology and partly because of the crazy quilt of laws and abortion attitudes in the US, the baby will be kept alive. Who will take responsibility for such an infant, aborted because of an anomaly and further severely compromised by the method and time of delivery? Is the mother to be forced to take the baby back? Or does the baby become a ward of the state?"

Screening for disease after birth can also cause families anguish. One workshop participant cited the case of screening newborn males for Duchenne muscular dystrophy, for which there is no treatment. "Of what possible use could it be to hang 'the sword of Damocles' over some poor family and make them watch each day for the first sign of deterioration in their son? And what if it were a false positive? Perhaps one could make a case for early diagnosis so that the parents know they are at risk before they proceed to have another child who might be similarly affected...In my view, that relatively small advantage hardly justifies the potential anguish such a screening program could create."

Screening for carriers of genetic diseases could also have repercussions. (Carriers are members of the population who do not manifest the disease, but have genes which, given appropriate matings, may produce affected children.) In one survey carried out in conjunction with a Tay Sachs screening program, a small percentage of those diagnosed as carriers felt their self-image was diminished (and an equal number of non-carriers felt their image was enhanced.) Half of the carriers felt worried or depressed immediately after the tests, but these feelings persisted for some time in less than 2 per cent of the cases.

Two other major issues relating to prenatal diagnosis were discussed at the workshop: the question of access to diagnostic services and the question of legal liability, especially of family physicians.

It appears that only a very small percentage of women who qualify for amniocentesis receive it; and they are mostly well-educated urban women who have heard about the procedure through the media and take the initiative in seeking out a prenatal clinic. Several reasons were cited for this situation: attitudes toward abortion, fear of the risks associated with the procedure, ignorance about genetic risks in general,

inability to pay travel costs. But resistance and negative attitudes on the part of family physicians was described as a major stumbling block; it was reported that at the time of the workshop only 2.3 per cent of the last 300 patients, in one Canadian centre, receiving amniocentesis had been referred by their own obstetricians.

But, in his article in the *Canadian Family Physician*, Dickens warns that doctors may leave themselves wide open legally if they do not give adequate genetic advice and guidance to their patients. "Family physicians are increasingly expected to identify indications of genetic defects in children and adults, to warn patients of genetic risks to the children they may conceive,

A background paper prepared for the workshop on human genetics outlines some of the unexpected social hazards that can occur if mass screening for a genetic disease is initiated too hastily, without adequate educational precautions. The paper cites one such case, in which there was "much confusion on the part of both the medical profession and the public as to the medical significance of (the) trait and many were stigmatized by the mistaken belief that the (carrier) state is a disease. Often, the results of the screening program were communicated to the individual by postcard, with little or often unintelligible information. Imaginary symptoms of fatigue, exercise intolerance and headache have been reported, and many thought they should be on special diets with vitamin supplements. Information was leaked to insurance companies and employers, and (carriers) were asked to pay higher premiums, were excluded from jobs and from some branches of the armed forces. Airline stewardesses were fired from their jobs in the mistaken belief that they would be worse off than the rest of us should an airplane cabin depressurize at 30,000 feet. In a screening program in Greece, young females known to be carriers became ineligible for marriage, and there have been a number of occasions when the tests results clearly indicated non-paternity, resulting in break-up of families."

and to advise specialized counselling when it is appropriate. They must know the genetic services in their communities and, for more extreme conditions even beyond their communities — for instance, in university-located medical genetics centres. Their legal negligence lies not in being incorrect in their diagnosis or advice, but in exercising their judgment on the basis of inadequate (including outdated) genetic and resource information."

He noted that in the United States negligent reproductive services, including genetic advice causing the birth of a damaged child, provide a legal cause of action, and said that Canadian courts could well move in this direction.

A speaker at the workshop said that successful suits have been brought against US obstetricians who failed to inform their patients of the increased risk of Down's syndrome beyond the age of 35. The issue of refusing amniocentesis to women under 35 (usually because of the workload at the clinic) was also raised; one participant said: "I feel I have no legal protection if I refuse."

Several speakers stressed the need to increase educational programs, not only of the public but of the family physicians. In his article, Dickens recommended immediate consideration of promoting genetic counseling to "a fully constituted speciality, with appropriate licensing of practitioners, accreditation of instruction, and monitoring of standards."

As one speaker concluded, the most important limiting factor on making cautious and competent genetic screening a part of preventive medicine may be education of the public, of health professionals, and of members of the government. "The task will be formidable, because of current levels of unawareness and misunderstanding, but comprehension of the general principles of human biology and realization that we all share the load of deleterious genes may help diffuse some of the touchy ethical and social issues..."





## How it's done

Basically, the nursing audit is accomplished through periodic assessment and evaluation using previously developed outcome criteria. The method of audit we use is called "Intermittent Retrospective Patient Outcome Review"; the name emphasizes once again the fact that the audit procedure is an examination not of nursing activity but of the results of nursing care.

The technique allows us to accomplish three objectives:

- to measure the level of patient care in objective, quantified, patient outcome terms
- to communicate to the nursing staff our survey findings
- to conduct educational programs to improve our standards of care for patients and their families.

We study nursing care by first selecting a specific patient population; for example, we may decide to focus on "long term patients" or patients who have "diabetes as a secondary disease entity". Audit criteria are then developed and charts are reviewed to determine whether or not the various criteria are being met. Findings are tabulated and the results are presented to the nursing staff using various visual aids, revealing strengths and weaknesses in the care being given. Educational programs are planned around our findings.

The audit program does not work in isolation — it is integrated with the work of other programs and committees within the Department of Nursing, and is thus one of several tools concurrently being used in nursing's overall program to improve patient care.

## The Committee

The initial work of the nursing audit program at MGH began several years ago when a 13-member central audit committee was formed, consisting of representatives from nursing administration, supervisors, teachers, clinical nurse specialists and staff nurses. The central committee continues to function, but does not itself perform the actual audit. The role of the committee is to determine the appropriate base from which to develop criteria and to ensure that the program as a whole is successfully maintained and ongoing. The committee reviews and refines audit criteria as developed by other nursing staff members, and it does carry out trial audits.

## In a nutshell

Developing the criteria has proven to be one of the most valuable aspects of the entire program. We believe this has to be done on a team basis if the results of the audit are to have any meaning or credibility. In other words, the staff

nurses who are directly involved in caring for patients and their families — the clients for whom these criteria are being written — must be the people who actually identify and develop the relevant audit criteria.

Here's how it works in practice. The head nurse, nurse clinician, and staff nurses from various nursing units (psychiatry, for example) meet on a number of occasions with a member of the central audit committee also in attendance. This group of nurses identifies the critical indicators of nursing care and then writes the criteria for their own area. Not all meetings are attended by the same nurses: those who are on duty and available at meeting time write the criteria. In this way, more nurses are able to take part in the audit, and staff who are often on evening or night duty get a chance to participate.

We have learned that generally the more nurses included in criteria development, the more successful the subsequent audit. The nurses who work most closely with the patients come to a consensus on what kind of care patients should be getting, and their judgment becomes the criteria upon which the audit is based.

The central committee member who attends these meetings acts as a leader of the group and takes notes to help keep all group members up to date. The team approach gives audit results more credibility and also ensures that a set of criteria will be identical for a specific group of patients regardless of where in the hospital the patient stays. For example, since a broad cross-section of psychiatry unit staff are involved, a common set of criteria for a chosen patient population will apply to all psychiatric units.

Audits are performed every two weeks year round on a pre-arranged audit day; currently we use the slogan "Pay Day is Audit Day". A sample of patients' charts, typically about 30, is drawn from Medical Records and inspected to determine how well the various criteria are being met; the audit is done by staff nurses who are again most closely involved with actual patient care.

Because sample sizes are determined as a percentage of the total patient population the actual number of charts reviewed in a single audit may vary greatly; for example, the number of charts used in an obstetrical audit could be as high as 60, while a hip pinning audit may require only 12. It takes just 20 minutes for a nurse to review a chart and thus it is relatively easy to free a nurse from her unit for this length of time.

Findings are tabulated and submitted to members of the "Nursing Standards and Evaluation Committee",

# Nursing Audit

## What's it all about?

*Shirley Sultan*

The nursing audit program at The Montreal General Hospital is an educational activity designed to improve nursing care; it is a program carried out *by nurses for nurses*. Rather than evaluating specific individuals or nursing units, the goal of the nursing audit program is simply to study nursing care throughout the hospital.



Figure one

# OUTCOME CRITERIA FOR PATIENT WITH HIP PINNING (60-80 years) DISCHARGED TO CONVALESCENT HOME

See nursing history, nurses' notes and standard care plan, intake and output sheet, med. sheet, nurses discharge summary.

Developed by Orthopedic Nursing Staff — Staff Nurses, Head Nurses and Nurse Clinicians

Criteria	Instructions to the Auditor		Met	Not Met	Exc.	Comments
<i>Pre-op</i>						
1. Verbal or non verbal expression of comfort	1. See nurses' notes for quality, site and degree of pain, also patient's response to Medication and or nurses' action, e.g. (positioning and Buck's Extension) (Chart once a shift)	1.				
2. Patient's skin is intact	2. Criteria not met if skin breakdown occurs. Exception if patient admitted with pressure area. (Chart once a shift)	2.				
3. Patient's hydration maintained	3. Criteria not met if no documentation of I.V. intake. (Chart once a shift)	3.				
<i>Post-op</i>						
4. Verbal or non verbal expression of comfort	4. Criteria not met if patient response to analgesia and/or nursing measures not indicated. (Chart once a shift for 48 hours).	4.				
5. Patient's wound remains clean	5. Criteria not met if patient's dressing is not changed when contaminated. Exception if wound is infected at 1st dressing change and M.D. notified. (First dressing change usually P.O. day 10).	5.				
6. Patient breathing easily	6. Criteria not met if respirations are labored, sounds congested or abnormal sputum. Exception patient with underlying chest conditons. (Chart once a shift for 48 hours).	6.				
7. Patient's skin is intact	7. Criteria not met if skin breakdown occurs. Exception if patient admitted with pressure area. (Chart once a shift for 48 hours then once a day until discharge).	7.				
8. Patient is free of contractures	8. Criteria met if patient demonstrates active and passive ankle and foot exercises on affected and unaffected leg. Criteria not met if patient develops contractures or foot drop. Exception if patient admitted with contractures. (Chart Q shift for 48 hours then once a day until discharge).	8.				
9. Patient is ambulatory with walker and not weight bearing on affected leg	9. Criteria not met if not walking by P.O.D. 5. Exception if patient was not ambulatory on unaffected leg prior to admission (2 or 3 x up with walking and tolerated) (Chart once a day from day 5 until discharge).	9.				

a nursing administration patient care committee. Results are then circulated to head nurses and in turn to staff nurses on the individual nursing units. Positive aspects and trends, as well as deficiency areas, are highlighted.

Audits are repeated in each patient area at approximately six-month intervals according to a projected schedule for the year. Operating in this manner, the audit has evolved into an

established program involving many of the nursing staff in the medical and surgical areas, and several specialty areas (see Figure one).

## Positive results

The nursing audit is not a panacea — it is merely a tool to be used by nursing managers to provide the best possible nursing care. For example, it is an effective data base development

instrument, providing statistics on patient care throughout the hospital which can in turn be used for the definition and development of nursing education programs. In this respect, audit is readily integrated with overall nursing department goals.

Our nursing audit provided useful information, supported by hard figures, that substantiated a feeling many of our nurses already had — namely,



that we could and should be managing our patients' pain more effectively. Opinions on the subject in the past were always subjective and varied, and it was always difficult to promote the need for change simply on the basis of such subjective individual opinions alone. Now, that these views are supplemented by a real data base, the audit has facilitated discussions on the management of pain.

The study of pain management in the hospital is an excellent example of how the audit process should work: because the audit criteria for pain are the same in many different audits throughout the hospital, we were able to study pain whenever an audit was performed. The results showed that we needed to improve nursing care in this area and that further study and action were called for. Pain management became a priority within the Nursing department and the nurse clinicians arranged various educational activities. Generally conferences were held on the nursing units, using visual aids such as slides and graphs; the hospital pain center was involved too in that a nurse was added to the team working in the center, which is a consulting unit dealing with the treatment and research of chronic pain problems. Pain also became one of the topics for Nursing Grand Rounds, which have become a popular event held every six weeks.

In short, the assessment of pain, methods used and evaluation of these methods were all given special attention, and results over an 18-month period show a definite and encouraging trend toward improvement.

### Education

The audit has pointed out the need to improve our teaching skills as nurses: nurses appear to have become more aware of their own role as teachers for patients and their families and the audit has encouraged the preparation of instructional material upon which to base staff development. At the same time it has acted as a stimulus for the use of new teaching methods for the nursing staff; for example, the chart review is really an exercise in which the nurse auditor learns "by doing".

As in pain management, where deficiency areas have emerged, Inservice Education has been able to develop programs aimed at effecting improvements. For example, workshops and Nursing Grand Rounds have been organized based on the results of the audit on "Diabetes as a Secondary Disease Entity". Criteria have been developed to apply to any patient hospitalized who has diabetes as a secondary medical condition — in other words, not a newly diagnosed diabetic, but a person hospitalized for other medical or surgical reasons. Through

the audits, hospital nurses are given an opportunity to assess how patients and family are managing to control their diabetes, which is a major health care problem in the community. Nurses are thus in a more advantageous position to practice the principles of preventive health care in their work by ensuring that patients and family are indeed able to care for themselves at home.

Communication has also been improved through the audit. When a group of nurses from various units with different levels of experience, knowledge and skills in nursing decide to meet on a regular basis in order to come to a consensus on what the nursing care for their own patients should be, positive communication naturally results.

Everyone takes part in group discussions, everyone is forced to think through his or her personal standards of nursing care and his or her own approach to caring for a particular group of patients; a free exchange of viewpoints and opinions occurs; there is a sharing of ideas, concerns and feelings. We believe all this fosters a healthy environment for communication which leads to greater knowledge and understanding.

The audit committee also served as a structure within which communication between staff nurses and supervisors could be improved. For example, it was noted that various forms in the hospital were not always used efficiently and nurses who were not using the discharge summary sheet in their areas saw the benefits and were consequently more ready to adopt it.

Concurrently, the nursing audit provides an opportunity to keep in touch with nursing practices outside one's own specialty area; on audit days nurses from surgery may be auditing obstetrical patients while OB nurses may be looking at long term care patients. This mingling of nursing experience and outlook is particularly beneficial in a large teaching hospital.

### Nurses looking at nurses

The purpose of the nursing audit is to allow nurses to see the results of nursing care; audit is not peer review, and it is in no way a threat to staff. The process is a voluntary one, nurses have a choice about getting involved, but the opportunity for nurses to become more directly involved in decisions affecting patient care is obvious.

To this end, documentation is important and must reflect the actual quality of the care being given. The results of the audit rely upon the assumption that we communicate results of nursing care accurately in our nursing records.

Nursing records are not, of course, always reliable, but we believe a

correlation exists between the documentation and actual nursing practices. As documentation improves, so may the care we are giving, and vice-versa. This is as yet an untested theory but in time nurse researchers may prove or disprove the hypothesis. Another problem is that there are undoubtedly many nursing practices carried out which remain undocumented; we are in the process of designing techniques that will enable us to measure and assess this phenomenon.

Clearly, accurate documentation is going to become even more important in the future; patients will acquire the right to review their own records and as more patients become aware of this right, they will exercise it. At the same time much has been written regarding the legal liability inherent in the accurate recording of events. Thus, what we record today is vital, and the incentives to improve that process are growing. Accordingly, the documentary aspect of the audit process can only be strengthened.

### What's it all about?

The audit belongs to the nursing staff. It is designed to be a tool to be used in improving patient care and to assess patient results in a meaningful, quantitative way. The nurses state what patient care should be, they develop criteria based on this appraisal, they do actual chart review, and they take part in the planning and the conducting of the educational programs that result.

Naturally, the audit process is not perfect, and the nursing staff is not entirely satisfied, but we intend to continue working within the same framework and we can make adjustments and improvements along the way. We are beginning to meet with people in other disciplines in our hospital — dietitians, physiotherapists, social workers and physicians — to explain our objectives and approach in the hope that we may one day have a multidisciplinary approach to audit.

Looking to the future, nursing audit encourages nursing study and research. For the nurse researchers, an abundance of useful factual material is being collected. ♡

*Shirley Sultan, a graduate of the Vancouver General Hospital School of Nursing, received her B.Sc. and M.Sc. degrees from Boston University. With experience in many areas of nursing in both Canada and the United States, she is currently a nurse clinician and Chairman of the Nursing Audit Program at the Montreal General Hospital.*



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## UPDATE ON DYSMENORRHEA

# CNA Code of Ethics: an ethical basis for nursing in Canada



Canadian Nurses Association  
50 The Driveway  
Ottawa, Ontario  
K2P 1E2  
1980

\$0.50  
ISBN 0-919108-50-4

3. Canadian Nurses Association, *Code of Ethics for Nurses*, 1978.  
4. Anderson, A.B.M., Haynes, P.J., et al: *Lancet* (1): 345-348, 1978.  
5. Consensus independent research, 1978. Data on File. Parke-Davis Canada Inc.

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with analgesics, or simply accepting their

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### cal picture

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smenorrhea.

### enorrrhea

thesis—the enzyme system responsible for  
bit the enzymes of the prostaglandin

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There have been a few reports of hematopoietic side  
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**SUPPLY:** Each ivory capsule with aqua blue cap  
contains 250 mg mefenamic acid.  
Bottles of 100 and 500 capsules.

FULL PRESCRIBING INFORMATION ON  
REQUEST.





# Ponstan\*

(mefenamic acid)

## FOR PRC OF DYSM

- \* non-hormonal, non-steroidal (simple, short-term taken only when required)
- \* inhibits prostaglandin synthesis, the action of prostaglandins on smooth muscle<sup>1</sup> (relaxes uterine contractions and aches)

### Ponstan Capsules 250 mg

2 capsules at onset of pain, followed by 1 capsule 4-6 hours; the duration of symptom relief is 8-12 hours.

\*Reg. T.M./M.E. Parke, Davis & Company

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Parke-Davis Canada Inc., Scarborough, Ontario

### I. Introduction

Nursing is a person-oriented health service. It is a service called forth by the experience of human pain and suffering, and directed to the promotion of health, the prevention and alleviation of suffering, and the provision of a caring presence for those for whom cure is not possible. The ethical norms that guide this service evolve from a belief system that perceives the human person to be of incalculable worth, and human life to have a sacred, precious and even mysterious character. Nursing is practiced in the context of human relationships, the dominant ethical determinant of which is the principle of respect for persons.

The concept which constitutes the unifying and ethical focus for nursing practice, education, administration and research is the concept caring. Caring, as a characteristic descriptive of all authentic human action, is expressed within the discipline of nursing through the following attributes. 1. *compassion*—the human response through which nurses participate in the pain and brokenness of humanity, by entering into the experience of another's suffering, misfortune or need in such a manner that the needs of that person are the primary basis for the use of the nurse's personal and professional skills.

2. *competence*—the state of having the knowledge, skills, energy and experience adequate to provide the required service.

3. *conscience*—the sense of what is right or wrong in one's conduct, and the awareness of, and the will to apply relevant ethical principles.

4. *confidence*—the quality which fosters the development and maintenance of trusting relationships.

5. *commitment*—a pledge, based on free choice, to devote oneself to meeting one's professional obligations.

In nursing, the human capacity to care is developed and professionalized through the acquisition of those intellectual, affective and technical skills required to carry out the responsibilities of specific nursing roles. The ethical obligations arising from caring as required by these roles are met at different levels of practice and within varying contexts. This statement considers three categories of obligation, namely, *caring and the profession, caring and the healing community, and caring and the individual nurse.*

### II. Caring and the profession

The nursing profession as a whole has ethical obligations to society as well as to its own membership. The profession has an obligation to examine its own goals and the service it offers in the light of existing health problems, and to design its programs in collaboration with other professions which also provide health services within the society. Nursing, in keeping with its mandate as a service profession, is bound to see itself, not as an end to be promoted and served by society, but as a professional body, constituted and legitimized by society's approval, to offer a prescribed service required for the improvement of the health status of people.



# UPDATE ON DYSMENORRHEA

In meeting its obligations to society, nursing has responsibility for monitoring the quantity and quality of persons entering the profession, and for identifying and implementing standards that promote the type and quality of nursing service dictated by society's needs. Nursing has a related responsibility to work for those conditions which will enable its members to provide the quantity and quality of service deemed necessary and desirable.

The nursing profession also has responsibilities to the international community. Since health is a basic condition for human development, and as no one nation or country can develop its potential in isolation, the interests of the profession transcend national boundaries. In fact, our credibility as a profession is called into question if we do not collaborate on an international level to promote the health of all peoples, and to work toward the relief of human suffering wherever it is experienced.

These broad obligations constitute the grounds for the ethical responsibilities of nursing's organized professional body, and include the following commitments:

1. In the context of existing health needs and problems, to identify Canada's need for nursing activities and services.
2. To establish relevant and realistic goals for the profession of nursing within Canadian society.
3. To foster collaboration with other health professions, political bodies, and other agencies in responding to the health needs of Canadians.
4. To collaborate with professional groups, institutions and agencies in promoting the welfare of peoples in other countries of the world.
5. To provide measures which will ensure that only those with the potential, motivation and discipline required to function as caring persons are accepted into, and endorsed by the nursing profession.
6. To work for the realization of working conditions which enable nurses to function as caring persons with the required degree of autonomy.
7. To promote conditions for nurses which provide for legitimate personal, professional and economic rewards.
8. To demonstrate, in its own transactions, accountability for the use of internal and external resources.

## III. Caring and the healing community

The attainment of health, in a holistic sense, requires services from a variety of sources, professional and non-professional. Health disciplines constitute one such source of service, and nursing, as one of these disciplines, is directed by its own unique focus and prescribed boundaries. The achievement of personal and family health goals depends upon a sensitive, deliberate fusion of the knowledge, skills and resources of all involved in relevant helping services. In health care today, a commitment to the collaboration essential for this process is a fundamental ethical imperative for health professionals. Where such collaboration is visible and operative, it constitutes an authentic sign of a caring, healing community.

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With the growing numbers and categories of people providing services in an increasingly complex health care system, the provision of a caring, healing community may be considered a courageous undertaking. Present experience leads some critics to conclude that the present health system is anything but a caring, healing community. Based on the observations of such critics, it would seem that each health professional group is committed to its own various and sundry goals—teaching, practice, administration and research—with token recognition of needs of clients, and, in some cases, operating in adversarial relationships with colleagues in other disciplines.

Many, if not most, of the ethical problems experienced by nurses today have their roots in conflict with other health professionals over what constitutes appropriate care for their clients. Such problems include, for example, confusion and open disagreement about the nature, extent, and timing of information required by patients and families; the initiation and/or prolongation of specific treatment protocols; the use of patients in teaching and research; disclosure of information and intrusions of privacy; threats to clients from known or potential abusers; evidence of incompetency, incapacity and negligence on the part of health care providers; and limitations on the freedom of nurses themselves to provide services for which they are prepared.

In the face of these issues, it is not sufficient that a nurse maintain 'personal' ethical behavior: responsibility to clients demands a stance which promotes care, and challenges actions which are contrary to acceptable health care goals. When quality of care is jeopardized, merely to 'live by one's own standards' with the attitude that what someone else does is 'none of my business', is to abdicate one's ethical responsibility for promoting the welfare of persons who require health services.

Other conflicts evolve from management relations and working conditions which, from the perspective of the nurse's legitimate needs and rights, may constitute grave violations of justice. In the efforts made to resolve such injustice, there is a serious responsibility to use only those methods which are, in themselves, in accord with ethical principles.

The responsibility to care makes fundamental claims on a person who chooses to enter the profession of nursing. This responsibility is exercised in responding to the needs of others, and the duty to provide needed services remains in the face of conflicting demands which may effect the welfare of the nurse in question. Thus, when a nurse is working under conditions which violate justice, the withdrawal of needed services to patients as a means of resolving such injustices, is unethical. This is not to downplay the gravity or the unethical character of the injustice itself, nor is it to imply that nurses ought to do nothing.

The assurance of working conditions where nurses can fulfill their caring obligations, and through which they can receive just recompense, is a professional obligation which ought not be delegated, and the resolution of conflicts arising out of such working conditions calls for the wisdom and dedication of the whole profession. From an ethical point of view, neither the profession as a whole, nor the individual nurse, may resort to strategies that would compromise the health of clients.



# UPDATE ON DYSMENORRHEA

In meeting the collaborative responsibilities inherent in the caring, healing community, the individual nurse does not relinquish the right nor the responsibility to adhere to personal moral principles. The nurse as a moral person has the ethical responsibility to refuse to participate in programs, treatments or procedures, and to withdraw from situations which are contrary to his or her informed moral conscience.

The design and on-going development of a caring, healing community requires, on the part of all concerned, an ethical sensitivity of the highest order. It presupposes, and is built within, a climate of mutual trust and respect. Nursing does not bear the burden of this responsibility alone, but nursing does have the obligation to contribute its insights and professional resources to bringing about the realization of such a community. In fact, a commitment to work toward the establishment of a truly caring, healing community may be the most critical and fundamental ethical challenge to the nursing profession at this particular time in its history. This ethical challenge is addressed to nursing as a whole through its professional bodies, and to nurses as individuals—educators, practitioners, administrators and researchers.

No code of ethics can, nor ought it try, to delineate the possible ways in which such a challenge may be met. Such will be accomplished through the efforts of caring nurses — persons who are themselves compassionate, competent, conscionable, confident, and committed — and who have the resourcefulness and creativity to design suitable models and select appropriate measures for implementation.

## IV. Caring and the individual nurse

The final test of the credibility of ethical standards in nursing lies in the behavior of the individual nurse—educator, practitioner, administrator and researcher. Many of the responsibilities arising out of obligations of the profession as a whole, and the ethical demands of the caring community itself, are fulfilled only in the actions of the individual nurse. While the profession has the obligation to identify, promote and monitor ethical standards, the execution of such standards is a personal responsibility, the final guarantee of which is in the conscience and commitment of the individual nurse.

## V. Guidelines

The following guidelines include general principles, with statements of ethical responsibility which flow from these principles. They are intended to provide a guide for reflection and for the articulation of more specific ethical rules and standards applicable to concrete experiences. With the increasing complexity of ethical conflicts in nursing, and the potential for greater ethical concerns in the future, ethical discernment in nursing is an exciting challenge, requiring knowledge, skill and great moral sensitivity. We have the capacity to meet this challenge—one which could be the greatest in the history of our profession.

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**SUPPLY:** Each ivory capsule with aqua blue cap contains 250 mg mafenamic acid. Bottles of 100 and 500 capsules.

FULL PRESCRIBING INFORMATION ON REQUEST.

3. Puikkinen, M.O., Kaihola, H.L., Acta Obstet Gynecol Scand 56:75-76, 1977

4. Anderson, A.B.M., Haynes, P.J., et al: Lancet (1): 345-348, 1978

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#### *General Principles*

1. The human person, regardless of race, creed, color, social class or health status, is of incalculable worth, and commands reverence and respect.
2. Human life has a sacred and even mysterious character and its worth is determined not merely by utilitarian concerns.
3. Caring, the central and fundamental focus of nursing, is the basis for nursing ethics. It is expressed in compassion, competence, conscience, confidence and commitment. It qualifies all the relationships in nursing practice, education, administration and research including those between nurse-client; nurse-nurse; nurse-other helping professionals; educator-colleague; faculty-student; researcher-subject.

#### *Statements of Ethical Responsibility*

1. Caring demands the provision of helping services that are appropriate to the needs of the client and significant others.
2. Caring recognizes the client's membership in a family and a community, and provides for the participation of significant others in his or her care.
3. Caring acknowledges the reality of death in the life of every person, and demands that appropriate support be provided for the dying person and family to enable them to prepare for, and to cope with death when it is inevitable.
4. Caring acknowledges that the human person has the capacity to face up to health needs and problems in his or her own unique way, and directs nursing action in a manner that will assist the client to develop, maintain or gain personal autonomy, self-respect and self-determination.
5. Caring, as a response to a health need, requires the consent and the participation of the person who is experiencing that need.
6. Caring dictates that the client and significant others have the knowledge and information adequate for free and informed decisions concerning care requirements, alternatives and preferences.
7. Caring demands that the needs of the client supersede those of the nurse, and that the nurse must not compromise the integrity of the client by personal behavior that is self-serving.
8. Caring acknowledges the vulnerability of a client in certain situations, and dictates restraint in actions which might compromise the client's rights and privileges.
9. Caring, involving a relationship which is, in itself, therapeutic, demands mutual respect and trust.
10. Caring acknowledges that information obtained in the course of the nursing relationship is privileged, and that it requires the full protection of confidentiality unless such information provides evidence of serious impending harm to the client or to a third party, or is legally required by the courts.
11. Caring requires that the nurse represent the needs of the client, and that the nurse take appropriate measures when the fulfillment of these needs is jeopardized by the actions of other persons.



# UPDATE ON DYSMENORRHEA

12. Caring acknowledges the dignity of all persons in the practice or educational setting.
13. Caring acknowledges, respects and draws upon the competencies of others.
14. Caring establishes the conditions for the harmonization of efforts of different helping professionals in providing required services to clients.
15. Caring seeks to establish and maintain a climate of respect for the honest dialogue needed for effective collaboration.
16. Caring establishes the legitimacy of respectful challenge and/or confrontation when the service required by the client is compromised by incompetency, incapacity or negligence, or when the competencies of the nurse are not acknowledged or appropriately utilized.
17. Caring demands the provision of working conditions which enable nurses to carry out their legitimate responsibilities.
18. Caring demands resourcefulness and restraint — accountability for the use of time, resources, equipment, and funds, and requires accountability to appropriate individuals and/or bodies.
19. Caring requires that the nurse bring to the work situation in education, practice, administration or research, the knowledge, affective and technical skills required, and that competency in these areas be maintained and updated.
20. Caring commands fidelity to oneself, and guards the right and privilege of the nurse to act in keeping with an informed moral conscience.

*Prepared for*  
**Canadian Nurses Association**  
*by M. Simone Roach, RN, PhD, csm*  
*and*  
*approved by*  
**Board of Directors**  
*February 1980*

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# UPDATE ON DYSMENORRHEA

## Shortcomings of traditional therapies

Surveys show that up to half of female patients may live a sixth of their reproductive years in pain. Yet many of these women are reluctant or embarrassed to talk about their problem, preferring to self treat with analgesics, or simply accepting their condition.

The Lancet, as recently as 1978, reported: "Current treatment of primary spasmodic dysmenorrhea is unsatisfactory. Powerful analgesics may be habit forming, dilatation of the cervix may cause incompetence, and the use of oral contraceptives seems unjustified unless contraception is required."<sup>2</sup>

## How prostaglandins fit into the clinical picture

In the 1940's it was theorized that a 'menstrual toxin' existed which was involved in causing the pain and other related problems. Recent investigations have indicated that increased premenstrual endometrial prostaglandin levels (particularly levels of prostaglandins  $E_2$  and  $F_2$  alpha) may play an important role in the etiology of dysmenorrhea.

## How Ponstan assists in relieving dysmenorrhea

Most non-steroidal anti-inflammatory agents are inhibitors of prostaglandin synthesis—the enzyme system responsible for the formation of prostaglandin.

The fenamate group of anti-inflammatory drugs have a twofold action: they inhibit the enzymes of the prostaglandin synthesis pathway and also antagonize prostaglandins at the receptor sites.<sup>1</sup>

## Ponstan versus conventional analgesics

Recent clinical trials have demonstrated that Ponstan is, indeed, a useful drug in the treatment of dysmenorrhea, affording relief in some 89.3% of patients cycles.<sup>3</sup>

In a double-blind comparison of dextropropoxyphene/paracetamol capsules (2 caps of 32.5 mg/325 mg t.i.d.) and Ponstan (2 caps of 250 mg t.i.d.), Ponstan was significantly more effective than the analgesic combination on both clinically determined and subjective patient preference assessments. There was also less absenteeism in the group taking Ponstan.<sup>4</sup>

## Alternative therapy to oral contraceptives

Ponstan provides prompt relief of dysmenorrhea, and may thus be considered a more rational therapy than oral contraceptives.

In a recent survey, 55% of women taking oral contraceptives stated that these agents had not solved their dysmenorrhea problems.<sup>5</sup> Ponstan has demonstrated a much higher success rate without disturbing the normal hormone balance of patients. Unlike oral contraceptives, Ponstan is taken only when required, i.e. when menstrual pain becomes evident. For the rest of the month the patient may be free of medication.

## Ponstan: a simple short-term regimen

Patient acceptance of Ponstan is understandably enthusiastic. When pain appears, a patient takes two capsules stat, for fast relief, followed by one capsule every 6 hours for the duration of symptoms.

In addition, Ponstan is well tolerated. Extensive data supports the fact that side effects with short courses of treatment with Ponstan are restricted mostly to minor gastrointestinal disturbances.

### Prescribing Information:

#### PONSTAN CAPSULES 250 mg

**PONSTAN** (mefenamic acid) is an analgesic preparation with antipyretic, anti-inflammatory and antiprostaglandin properties. PONSTAN has been shown to inhibit both the synthesis of prostaglandins and their action on the cell receptor sites.

**INDICATIONS:** For the relief of pain in acute or chronic conditions such as dysmenorrhea, headaches and muscular aches and pains, ordinarily not requiring the use of narcotics.

**DOSAGE:** Administration is by the oral route, preferably with food. The recommended regimen for adults and children over 14 years of age is 500 mg as an initial dose followed by 250 mg every 6 hours as needed. PONSTAN should not be given to children under 14 years of age.

**CONTRAINDICATIONS:** PONSTAN is contraindicated in patients showing evidence of intestinal ulceration. The drug is also contraindicated in patients known to be hypersensitive to mefenamic acid. If diarrhea occurs, the drug should be promptly discontinued. Safe use in pregnancy has not been established.

**PRECAUTIONS:** PONSTAN should be administered with caution to patients with abnormal renal function and inflammatory conditions of the gastrointestinal tract. Caution should be exercised in administering PONSTAN to patients on anticoagulant therapy since it may prolong prothrombin times. PONSTAN should be used with caution in known asthmatics. If rash occurs, the drug should be promptly discontinued.

Mefenamic acid may prolong acetylsalicylic acid induced gastrointestinal bleeding. However, mefenamic acid itself appears to be less liable than

acetylsalicylic acid to cause gastrointestinal bleeding.

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- BIBLIOGRAPHY:** 1. Smith, I.D., Temple, D.M., et al: Prostaglandins 10: 41-57, 1975  
2. Kapadia, L., Elder, M.G.: Lancet (1): 348-350, 1978  
3. Pulkkinen, M.O., Kaihola, H.L.: Acta Obstet Gynecol Scand 56:75-76, 1977  
4. Anderson, A.B.M., Haynes, P.J., et al: Lancet (1): 345-348, 1978  
5. Consensus independent research, 1978. Data on File. Parke-Davis Canada Inc





"Thunder Bay is turned on to fitness", reports Frances Welch, BScN, M.Ed., Project Director of Health Promotion with the Thunder Bay Community Fitness Campaign (CFC). The citizens of the city demonstrated this when in September, 1979, 22,000 individuals registered to walk, run, bicycle or jog more kilometers than their twin, Brampton, Ontario, during a one week kick-off to their Community Fitness Campaign.

Thunder Bay's Community Fitness Campaign is a two-year project designed to encourage citizens to become more active, more frequently, more regularly and, in doing so to accept responsibility for their own health through lifestyle management. As a health promotion strategy, it also attempts to provide an environment which physically and socially supports fitness. While the project is very much based on a community development model, the focus has been placed on several different target groups including school-aged children, women, employees, community leaders, families, senior citizens and the aged, through a series of motivational, educational and fitness events.



As a demonstration project of the District Health Council, the Community Fitness Campaign has caused many elements within the community and the health care system to re-examine their services and mandates. Traditional fitness agencies, challenged by

this increase in non-traditional fitness events which provide participation for many and spectatorship for few, are forced to reassess their roles as community agencies. Consumers are beginning to demand improved access to fitness; they want the previous barriers of high cost, limited availability and rigid time scheduling eliminated. Also as more people become involved in fitness, clinically oriented fitness professionals are forced to reconsider the meaning of fitness for these new clients.

The traditional roles of existing community health agencies, as well as those of various health professionals are also being challenged by the presence of such a campaign. Strategies for conflict management have taken on new significance at both the individual and the planning level as issues affecting the development of fitness as a resource available for positive lifestyle management are delineated.

For nursing, CFC represents a challenge as it demands knowledgeable, feasible and client-compatible planning about how to market fitness, how to manage a community-wide nursing plan and how to cope with the conflicts that are bound to arise when any nursing

project attempts to facilitate lifestyle change within or outside of the existing health care system.



Photos courtesy of Weyerhaeuser Canada Ltd.

Eleanor Serviss, RN, is an Occupational Health Nurse for Weyerhaeuser Canada Ltd, at the Kamloops Pulp Mill, British Columbia. With 650 plant employees and 200 administrative employees situated five miles from the town of Kamloops and hospital facilities, Eleanor is kept busy with the normal occupational health nurse's duties and coping with the job hazards that are unique to a pulpmill, such as inhalation of various noxious chemicals and chemical spills and splashes in eyes and on skin. However, many hazards of these highly automated mills can be traced to the minimal physical activity required.

Although Eleanor has been promoting healthy lifestyles and physical fitness over the years, she was even more highly

motivated after attending the National Workshop on Fitness and Lifestyle for Occupational

Health Nurses. She took a closer look at her own lifestyle and in response set up a personal fitness schedule that included improving her diet, swimming twice a week, walking after work, using an exercise bicycle, skipping and doing specific exercises daily. Now she feels much better equipped to promote individualized fitness programs and does this daily through her contact with employees.

Eleanor believes that if individual counseling is done well, people can be made to want to keep fit and since it is then their own idea, the chances that they will be successful are greatly increased. Presently, she is holding two \$100 cheques in safekeeping for two employees who are competing with each other in a weight reduction contest.

Management has needed some convincing about their role in the fitness of their employees, but in the long run have been very supportive. An acre of land has been set aside for future recreation uses, exercise breaks have been initiated in many of the office areas, hours of work have become more flexible to allow

Everyone agrees that fitness is fine...for the other guy. A healthy lifestyle means a longer life...but what about right now, today? Are Canadian nurses accepting the challenge of integrating fitness and lifestyle teaching into their personal lives and into their professional roles?

CNJ wondered about that and, in an effort to find out, asked a sampling of occupational and community health nurses across the country, many of whom had attended one of the three national 'fitness workshops' for nurses at Geneva Park, to tell us what they are doing and how they are coping with the realities of initiating change in this area.

Judith Banning

# A personal commitment to fitness results in healthier clients



time for fitness classes at the local YMCA at noon and the company is sponsoring curling, hockey, baseball and golf. Eleanor also uses the *Weyerhaeuser News*, the company newspaper which circulates to employees in British Columbia, Ontario and Quebec, as a vehicle for her fitness and lifestyle teaching.

The company employees were not the only ones to benefit from her workshop attendance. Eleanor also met with the local Occupational Health Nurses group and shared her experiences and updated knowledge. Once a cover girl of the RNABC News, Eleanor retired officially in March, 1980.

For the employees living and working throughout rural Saskatchewan, promotion of fitness and lifestyle goes beyond exercise and physical activity which they often feel they have accomplished through their active jobs. Consequently, nutrition, weight control and smoking are a few of the topics that are considered. Use of the employee news publication, special annual health bulletins on smoking, availability of stop smoking kits, buttons and posters and correspondence with all new employees are the teaching methods used for these rural employees.



balls and frisbies. Unsweetened juices, fresh fruit and cheddar cheese are available through the food service and Marilyn has recommended to management that a walk/jog trail with exercise stations be developed around the perimeter of the building.

At the Head Office in Regina, there are 550 more employees. These sedentary office workers working in one location with little or no shift work, a full hour lunch break and community facilities close by, make the probability of a successful program quite feasible. Fitness posters brighten the coffee shop, YM-YWCA program brochures are given a high profile, an annual jog-a-thon is well advertised, films are shown regularly, articles on fitness and nutrition are inserted in the employees' publication, onsite Stop Smoking Clinics are held, fresh fruit, bran muffins and cheese are now available in the coffee shop and sandwich and soup machines have been installed for those who do not bring a lunch and previously had to settle for chips, a chocolate bar and a coke. A weekly weight club has been initiated and at the annual meeting, exercise breaks, nutrition breaks and a ban on smoking during sessions now prevail.

In the future, Marilyn is hoping for onsite lockers and showers, an exercise room, fitness testing facilities and an employee fitness committee which would promote various inter-departmental activities and more effectively represent the employees suggestions to management. If onsite facilities are developed, Marilyn feels that the employees should in some way share in the cost with management whether through reasonable monthly memberships, raffles or other fund-raising projects.

After attending the National Workshop on Fitness and Lifestyle for Community Health Nurses, Beth Truant, RN, PHN, decided to integrate fitness into her own professional nursing role. A public health nurse with the West Kootenay Health District, Trail, British Columbia, she began with an assessment within her working area of the benefits that might accrue from improved fitness and the methods that might be utilized. She realized her first step was to overcome her own lack of fitness through improved nutrition, keep-fit classes and generally improving her own lifestyle.

Her nursing colleagues were also concerned about their personal fitness levels and the problems of integrating fitness into their community work. With the support of management, enthusiasm grew. Beth coordinated the fitness and lifestyle component of a Mother's Parenting Group. Participants in the program were given fitness tests, counseled on their personal levels of fitness and how to improve these.

Soon Beth was distributing resource tapes and materials to a variety of groups, ranging from schools within her district to care facilities for the elderly. This resource development put her in touch with fitness consultants and she gained from their advice on weight control and exercise. Circuit training and exercise break tapes were then made available and Beth began noticing that fitness and lifestyle teaching were becoming part of all her duties including prenatal teaching, school duties and community projects.



Returning to her work area from the excitement of the Fitness and Lifestyle workshop, Marilyn Reddy, RN, found she had to redefine her enthusiasm in the light of the realism of her own work situation. Goals had to be modified and accomplishments seemed small at first but now she's hoping that major changes will soon be evident.

Marilyn is an Occupational Health Nurse with the Saskatchewan Wheat Pool, a farmer-owned cooperative employing approximately 4000. As there are several different operating divisions, there is a great diversity in the working environments of the employees. Establishing a fitness or lifestyle program either active or promotional in a rural area is difficult since personal contact by the health nurse is infrequent and in some widespread locations in Saskatchewan, very impractical; organized onsite exercise programs are not feasible as the number of employees are few and facilities unavailable, even community facilities in small hamlets are usually non-existent.

The Wheat Pool in Saskatoon includes the Western Producer Publication, a printing and publishing operation which employs more than 200 persons in a highly mechanized environment. Assembly line jobs become boring and although the need may be there, production usually cannot be interrupted for mini-exercise breaks or fitness or lifestyle programs. These problems are further accentuated by shift work, the lack of available space for onsite facilities and the location of the work site in the industrial section of the city far from existing community facilities such as the YM-YWCA or racquette clubs.

Marilyn visits the Western Producer only one day a month but has a good relationship with management and employees there. Besides the usual posters and literature, she suggested that a picnic site with tables be made available for the many employees who work all day on machines in windowless environments. Now there are tables, horseshoe games,



Although most employment in the Trail area requires a high degree of physical activity in the lead, zinc and silver smelters or in the pulp mills and logging communities, these people have not been immune to weight gain. The West Kootenay Health District is currently involved in a promotional campaign called a "Flab Fight" which is encouraging people to reduce their caloric input and to increase their physical activity. Actively promoted by local radio stations, the campaign encourages people to visit their local branch offices of the West Kootenay Health District to pick up a locally designed "Fat Kat Fit Kit".

As community health specialists, Beth believes that public health nurses must guard against overpowering clients with the fact that fitness is the panacea to all problems of western society, but it is important to understand that all aspects of life and lifestyle are closely linked and equal in their contribution to the quality of life an individual chooses.

Judy Proulx, RN, CHN, coordinated a pilot project, "Fun and Fitness", an obesity clinic in Cochrane, Alberta for children age six through fourteen. This project, a joint effort of the Mount View Health Unit and the Alberta Children's Hospital, Endocrine Clinic, utilized a team consisting of a physician, dietitian, physical education teacher and community health nurse.

Sixteen children were involved in the eight-week program which included a complete physical assessment and a three pronged approach to initiate change through use of diet, physical activity and lifestyle of the child and the family. The nutritionist met with each parent and child individually to discuss eating habits and ways of cutting back calories, to develop a personal diet according to age and weight and to emphasize family involvement (one parent was usually encouraged to join the child in dieting).

The one and one-half hour sessions began with a weigh-in and discussion of personal difficulties; during this time warm-up exercises including disco dancing and relay type exercises were taking place in the gym.

Then specific sports activities were organized, such as baseball, hiking or swimming to give the children new opportunities to experience their bodies. After cooling down, the children took part in nutritional discussions. Parent involvement was encouraged in all aspects of the program.

At the end of the eight-week period, there was a total loss of 106 pounds. Weekly weigh-in at the health unit during the summer was encouraged.



Photo courtesy of Dominion Bridge

Eleanor Martin, RN, is an occupational health nurse working with Dominion Bridge Company Limited in Winnipeg. Not only does she treat injuries which the steel plant workers may receive, but she is also making a concerted effort to improve safety on and off the job site. She describes some of the employee and management feelings about safety: "They think that is dull and boring. I have to convince them that safety is just as important as production. Every day lost to an injury is not only painful to the injured person: it is expensive to the employer, and costly to the community in the sense that it is the taxpayer who pays for medical and hospital services if they are required. Accidents *can* be prevented and prevention starts with an enlightened management."

Through the use of personal accident prevention meetings, with new employees, films, first aid courses and a regular safety newsletter sent to the employees' homes, safety on the worksite and also in the home is emphasized. Safety incentives are also used, such as draws for trips when specified numbers of accident-free days are reached.

Alison Black, RN, B.N.Sc., works with the Ottawa Centretown Community Resource Centre, a community health center with a difference. On staff at the center are seven nurses who function as independent, community-based practitioners, each of whom was largely instrumental in developing her own job description and initiating her own program.

Alison works with a "Lifestyles and Health Program" which entered its pilot stage 18 months ago. The program has a long term goal of helping individuals adopt healthy habits and lifestyles and maintain these for a lifetime. By focusing on lifestyle, personal responsibility for health and on learning skills for greater control over personal health, the basic precepts of nutrition, physical fitness and the constructive management of stress are taught.

During the initial 11-hour block of lectures, the effects of inadequate nutrition, physical inactivity, inappropriate methods of coping with stress (including smoking and the excess use of alcohol and drugs) and lack of purpose and direction are discussed. Health evaluations are done to help the participant assess and understand his own current overall health level, provide a baseline and motivate him to initiate change. The evaluations are not a search for illness, although any pathology indicated by abnormal results would be followed up by an appropriate referral to the family physician.

These evaluations which focus on health potentials, health hazards, stress and physical fitness levels, include a blend of measures from blood tests, blood pressure and pulse determination and other biometric measurements to a health hazard appraisal, life change measurements, indexes of well-being, cardiovascular risk assessment and fitness tests.

The final two hours of the initial block focuses on implementing a program for lifestyle change and health improvement relevant to the individual's situation and on providing access to supportive community resources.

Two subsequent sessions are held at six months and 12 months, to provide ongoing support, further information, reassess health status and reinforce and remotivate the participant.

The participants, ranging in age from 20 to 70 years, are referred to the program as high risk candidates by the Centre's own medical staff, by community physicians or agencies or come to the program on their own initiative having seen posters at the center or heard of the program from friends. Nurses and doctors as well as non-professionals make up this group, some using the course as a training session for their own role in community education.

Generally, the participants need help putting lifestyle information into a workable context. The most important segment of the program seems to be convincing these people that lifestyle does relate to acute and chronic diseases and explaining why. Then through the development of skills these individuals are able to make an informed decision about their life and know they can influence their health if they choose to. The final step involves assisting these individuals to develop realistic goals and specific manageable programs. This completes what has become a highly successful program.



Photo courtesy of Louise Mather





"Occupational health programs beyond the 'pill and patch' (first aid) concept are in their relative infancy in Nova Scotia," reports **Jean Nickerson**, Occupational Nursing Consultant with the Nova Scotia Department of Health. When CNJ asked her to share her experiences with our readers she went one step further and contacted occupational health nurses across the province.

**Gai Thomas, RN, BA, MSC**, of the Occupational Health Department of the Victoria General Hospital, Halifax, responded by describing their well-rounded lifestyle program which includes:

- "fit breaks", currently held weekly or bi-weekly at all work sites, with plans to increase these to daily,
- "fit walks", daily purposeful walks for 15 minutes in the immediate vicinity of the hospital which include a short exercise break along the way,
- a "non-smoking" committee which plans educational programs with highlights such as 'Weedless Wednesday' and 'Lungs for Life' slogans,
- a new employee recreation council which will organize and develop programs and has already designed T-shirts with the slogan "Getting Fit For the V.G. and Me" (the right to purchase these shirts must be earned by participants),
- an accident program has been developed in which the Occupational Health Department manages treatment of all day-time accidents, advises the Administration Department on policy and procedure, investigates all accidents, counsels all victims and co-workers, recommends repairs and improvement of mechanical and environmental contributors to accidents, reports to Workmen's Compensation Board, etc.,
- environmental concerns addressed through a new program of monitoring, investigation and cooperative hazard appraisal, and

- safety committees restructured and expanded and a new safety council formed in hopes of raising the collective safety consciousness of the employees and administration.

**Beverly LeBlanc, RN**, works with Devco health services at one of their nursing stations located at Prince Mine, Point Aconi. Although the nursing station operates on a 24-hour basis and is readily accessible to all workers, establishing a fitness and lifestyle program has been difficult because of the nature and hours of the coal miners' work. In response to this the nurses have established a special program each month designed to aid the workers in their daily life. These programs focus on a wide variety of themes such as nutrition, blood pressure, vision testing, weight control, blood sugar testing, etc., and are designed to educate as well as diagnose. They also increase the nurses' contact with the men, increasing their visibility on the work site for other than injury or illness consultation. Now the miners drop in to pick up information on healthy diets, to have a blood pressure taken or for a monthly weigh-in and their anti-smoking teaching is supplemented by the strict no-smoking policy underground, so eight hours of the miners' day is "smoke free".

About a year ago, **Mary MacNeil, RN**, an Occupational Health Nurse with the Point Tupper Refinery, Port Hawkesbury, a division of Gulf Canada, sat down with the local public health nutritionist to discuss how they should go about initiating a fitness and lifestyle program. What resulted is a program now well into its operational phase.

A fitness testing team from St. Francis Xavier University visited the plant site and 92 of the 138 employees participated in the testing and health inventories which made up the Lifestyle

Inventory and Fitness Evaluation program. Individualized print-outs featuring comparison with the average Canadian and recommendations for improving the evaluations were given to all participants.

Now a six-week nutritional and physical fitness education program is being prepared to focus on three types of fitness and lifestyle groups: first, those who will retain their status quo, second, those who will follow a personal program (self-maintenance) and thirdly, those who will follow a controlled program with an organized group. A recheck and comparison of data will be done at the end of the six-week program.

**Meg Macdonald, RN**, is an Occupational Health Nurse with a self-sufficient, multi-faceted electronics company made up of approximately 600 employees. While management seemed to focus primarily on production in the past, there now seems to be a growing concern within management for employee health. For Meg, the major barrier to establishment of a fitness program has been the short 30-minute lunch break and the lack of time for fitness breaks during the day. However, a group of women employees do carry out ten-minute stretch and bend exercise sessions outside in the warm weather and basketball baskets and balls are to be purchased for use this spring. Otherwise teaching takes place through the use of posters and one to one counseling on smoking, weight control, nutrition and use of leisure time. Soft ball, bowling and hockey teams have also increased in popularity.



**Evelyn Bickerton, RN**, staff health nurse at the Sydney City Hospital, reports that many departments in her hospital have become involved in fitness and lifestyle teaching. Two afternoons a week the hospital dietitian has made herself available to all staff with weight problems. Meal plans, diet charts, individual interviews and weekly weight checks are used. An alcoholism committee has been set up with representatives from the local Detox Centre and health service available to all employees. Along with confinement of smoking to specific areas, the use of audiovisual presentations on smoking, nutrition, dieting and alcoholism and the availability of up-to-date literature, the lifestyles of their employees will hopefully be improved.

Even the student nurses are benefiting, as a fitness program including exercises, dancing, outdoor jogging, swimming and organized sports has been incorporated into their nutrition classes.

**Norma Hooper, RN**, is an Occupational Health Nurse with Maritime Telegraph & Telephone Co., Ltd., a tele-communications industry with an employee population of approximately 3,500 people scattered throughout Nova Scotia from Sydney to Yarmouth and ranging from craftsmen and operators to clerical staff and professionals. Initially, a nutrition/weight control program organized in Halifax, Sydney and Kentville centers resulted in large numbers of employees participating in weekly weigh-in and nutritional counseling. The enthusiasm following setting up of this program led to the establishment of noon-time fitness programs initially in the Halifax region and now in some of the other centers. More recently a supervisors training program on alcohol and drug abuse has been implemented and more than 200 managers have been involved in the 12 one-day sessions held to date.

Promotion, awareness, group education of employees on a continuing basis, visibility and self-example are all tools in the continuing campaign to motivate employees to take that last, important step—active participation in an individual fitness program. ♡



# The light still shines in Elora

At the fork of the Irvine and Grand Rivers in southwestern Ontario, stands the small village of Elora. Here, housed in a rural Anglican church, are the remnants of an almost forgotten love story. This story holds a special interest for nurses because of the fact that the woman involved was none other than Florence Nightingale.

"The Lady of the Lamp", Florence Nightingale and her first cousin, John Smithurst, so the story goes, fell in love in England when both were very young. The fact that they were cousins made marriage out of the question so they decided to part, each taking up a new vocation: Florence, of course, became a nurse; John studied for the ministry, was ordained and, in 1839, left for the lonely frontier of Canada.

John Smithurst served as pastor of St. John's Anglican Church in Elora for many years, until his retirement in 1857, but before that happened, he was the recipient of a unique and lasting testimonial to his relationship with "The Lady of the Lamp". The gift was a



*Thelma R. May  
and Wendy J. May*

beautiful silver English communion set now on display in a special vault in the church. The inscription engraved on one of the silver pieces is in Latin. Translated it reads:

"Acting as an agent for someone, Ebenezer Hall gave, as a gift, this set of communion silver to Reverend John Smithurst, a

very dear friend, in grateful recognition of his many kindnesses. A.D. 1852" That "someone" was Florence Nightingale.

John Smithurst died in 1867 at the age of 59 and was buried in Elora Cemetery. His cousin Florence was buried in St. Paul's Cathedral in London, England, some 43 years later.

In years gone by, a special service for nurses was held in St. John's on the Sunday closest to the anniversary of Florence Nightingale's birth in May, 1820. Now, however, the communion set is used by the congregation only at Christmas and Easter although it is kept on display and the little church is always open to visitors.

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# Perceptual distortion



Geraldine Hart

**You helped your post-CVA patient, Mrs. West, into the chair not twenty minutes ago; when you return to her room, she is upset, saying she has been sitting there for “three hours” and has had to go to the bathroom. Her callbell is still fastened to the left arm of her chair where you left it. Mrs. West says she couldn’t find it to ring for help. Is she confused, or are her perceptions distorted?**

The nurse who does not understand or recognize the problem of perceptual distortion in a patient’s behavior cannot help but fail to ascertain the impact this deficit may have on the patient’s progress. She may, mistakenly, attribute his behavior to other causes — perhaps confusion or an uncooperative nature — which may lead to inappropriate nursing interventions and feelings of hopelessness and frustration on the part of both patient and nurse.

Normal perception involves the apprehension, reception and integration of all sensory input by the human brain, from within the body and without, such as touch, vision, hearing or position sense (proprioception); the result is that the normal human has an ordered understanding of the relationship of his body to the outside environment, and the parts of the body one to another.

Without this understanding, it is impossible for an individual to successfully accomplish the various skilled motor activities that are part of daily life.

Perceptual deficit may vary in both type and degree following a CVA that affects either side of the brain. In general, however, patients with *left hemiplegia* (right-sided brain damage) have more problems with perception, while those with *right hemiplegia* (left-sided brain damage) have more problems with language functions. Thus the problems discussed in this article will be most commonly found in stroke patients with left hemiplegia and intact language function.

While the absence of any difficulties with language may allow the nurse and patient to communicate and may ease the nurse’s assessment and management of problems, it is still easy to underestimate potential problems in rehabilitation.

Perceptual problems have a great effect on the patient’s level of independence. The impact of some of the facets of perceptual distortion are outlined below.

## **Lack of awareness**

The post-CVA patient may actually be unaware of the affected side of his body, and he may subsequently neglect it. This problem is due to a complex brain dysfunction; if the patient is not aware of one side of his body he will not use it, and if preventive measures are not taken he may develop further problems such as weakness or contractures, as severely as if he had actual paralysis.<sup>1</sup> Such a patient when attempting to wash or dress himself will believe he has finished when he has washed only one side or put only one arm into his hospital gown. A bizarre but occasional example of unilateral neglect of the body is the patient who thinks another person or a dead body is in bed with him because he sees or feels arms or legs that he cannot recognize as his own.



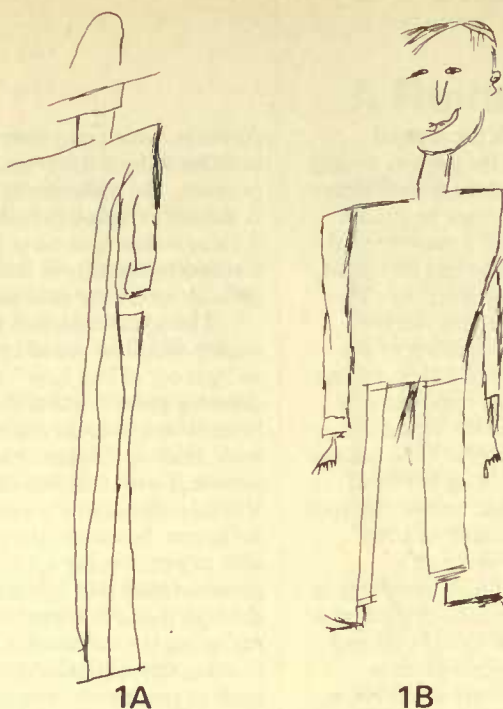


Figure one. Evidence of unilateral neglect in figure drawing.

Nursing assessment of this problem can be based on observation of spontaneous patient behavior as well as the patient's response to requests to touch various parts of his body. Another way the nurse can assess a patient's body awareness is to have him draw a human figure, either from memory or by copying a stick figure the nurse has drawn. Figure one illustrates the impact of unilateral neglect on figure drawing; this patient shows almost complete lack of awareness of the left side at 6 weeks (1a) and partial return of awareness at 27 weeks after a stroke (1b).

When doing any assessment that involves asking the patient to perform tasks that would have been simple before his CVA, the nurse must take care not to leave the patient with a feeling of frustration and failure. She should explain that the procedure will help her understand what problems he has and that she will help him cope with them.

While caring for a patient with body awareness problems, the nurse should take every opportunity to make the patient aware of his neglected side. This can be done when bathing or assisting the patient with his bath by bringing the neglected extremities to his unaffected side and naming each part as it is washed. Encouraging the patient to put on his clothes by himself, even if he is only wearing a hospital gown, is helpful if the nurse gives consistent directions and is ready to assist when the task becomes too frustrating.

There is great value in frequent repetition and consistency of approach when practicing such basic skills; when both are working with the patient, the nurse and the occupational therapist should consult so that they can establish and follow a routine with the patient.

In addition to his perceptual difficulty, the patient with left hemiplegia may have loss of direct sensation in his affected extremities, leaving him with no sense of touch or position on that side of his body which obviously makes overcoming unilateral neglect more difficult. The right hemiplegic patient, who does not usually have perceptual problems and thus remains aware that the affected side of his body exists, may have sensory loss alone. This means he cannot feel the pressure of his foot on the floor or of his arm on the mattress; he cannot feel whether his knee is bent or straight, or whether his arm is in front of or behind him. All knowledge of the affected limbs must come from touching them with his unaffected side or by looking to see where they are. Anyone who has ever had a limb "go to sleep" knows how awkward and useless this can feel.

In contrast to the left hemiplegic patient who may harm himself by ignoring one side of his body, the right hemiplegic patient tends to be overly cautious and even afraid to move if he has lack of sensation in his affected side.

This fear is often obvious in the desperate grip the patient has on the bed rail or nurse's arm when he is asked to move; however he may have accompanying language difficulties and he may be unable to say why he is afraid. The nurse can help overcome the patient's fear with physical support and frequent assurances that she will not let him fall. This patient can benefit from using a full length mirror to check the position of his limbs as he is relearning the activities of daily living.

### Distortions of spatial awareness

While a stroke can cause distortion of a person's perception of his body, it can also cause distortion of his awareness of space. Distortions of perception of space can be divided into three main areas:

- inattention to one side of space
- distorted perception of distance and vertical plane
- distorted figure-ground perception.

*Inattention to one side of space:* With stroke patients, problems of awareness of the affected side of the body are usually accompanied by inattention to the same side of the environment. However, in less extensive or resolving strokes one deficit may be seen without the other. When inattention to one side of the environment is present, the patient will eat the food from only one side of his meal tray or ask why the orderly did not return his urinal when it is hanging on the side of the bed he neglects. If he is mobile, he may tend to bump into door frames and furniture.

This neglect of one side of his environment is sometimes but not always accompanied by blindness in that side of the patient's visual field (homonymous hemianopsia). When actual blindness is involved, the patient will of course not see anything on his affected side. However, the patient with visual neglect only will often notice objects on his affected side if they are brought to his attention, or if the competing stimuli on his unaffected side are reduced, which can be done by placing his bed so his unaffected side is next to a wall. When blindness on the affected side is a major factor in the patient's inattention to one side of his environment, frequent reminders to the patient to turn his head in the direction of his blindness are often enough to lead him to the habit of constantly scanning his environment, thus compensating for his visual loss.



To ensure the patient's safety and to minimize frustration if the neglect of one side is severe, the nurse should place the call bell, urinal, bedside table, etc. on the patient's unaffected side. His bed should not be positioned so that his unaffected side is permanently against a blank wall as this can lead to sensory deprivation which often heightens any confusion present. However, at later stages of recovery and rehabilitation, the patient usually benefits from having his environment reorganized so that he is encouraged to work across his affected side. At this point, the objects he commonly uses should be placed on his affected side and his bed positioned so that sources of his social stimulation, for example, roommates and television, are available mainly on his affected side.

To summarize, a judgement of the most beneficial arrangement of the patient's environment must always take into consideration the need for safety and to avoid the patient's frustration, while at the same time encouraging him to reintegrate the affected side of his body into his daily activities.

**Depth perception:** Although they may be aware of the existence of space on their affected side, many stroke patients with left hemiplegia cannot accurately perceive distance or vertical plane. Depth perception is dependent on binocular vision, and in these patients this is disturbed which means they cannot tell how near or far objects are from them or what is straight up and down.

Distortions in distance perception may result in patients' bumping into objects, or falling because they misjudge the distance of a support for which they are reaching. Inability to perceive distance correctly may also cause patients to drop and knock over small articles they attempt to handle. Distortion in perception of the vertical plane leads to balance problems, in both standing and sitting positions and can be as much a cause of a patient consistently slumping to one side in his wheelchair as actual physical weakness; it can also explain the difficulty a nurse may have in getting a patient to stand up straight even though she is bracing his knee.<sup>2</sup>

Complicating both perceptual deficits is the fact that the patient usually seems to be unaware of these problems and thus attempts activities he cannot safely accomplish. Such a patient needs close supervision until he can be taught, through consistent reminders, to stop and test correct balance and distance before impetuously proceeding in any activity. With vertical distortion, telling the patient to lean to the opposite side can be effective. Use of the terms left and right will not be helpful if the patient has difficulty distinguishing left from right, another deficit that can result from a stroke. Observing himself in a full length mirror can also serve as a reminder to the patient with problems in sitting and standing balance caused by a distorted perception of straight up and down; when distance perception is distorted, leaving furniture in the room always in the same place may aid the patient to relearn correct distance judgement.

**Distorted figure-ground perception:** Another perceptual problem is lack of figure-ground discrimination; in other words, the patient has difficulty sorting out incoming visual stimuli and in focusing on one thing in particular. This means he may be unable to pick out a specific object in his environment from among others, and have special difficulty in knowing what object is on top of or in front of another. If there are many things on his bedside table, for instance, he may not be able to find the one item he wants, or, if his slippers are on top of his plaid bathrobe, he may not be able to pick them out. This patient will be easily distracted and have difficulty concentrating on any one thing; therefore, he will function better if his environment is kept uncluttered and objects are kept in the same place as much as possible. For example, at meal time he might manage better if food is put on his tray one course at a time.

#### **Apraxia**

The inability to visualize internally and to carry out the complex movements that are part of daily activities is called apraxia. Even with no attendant loss of motor power or sensation, the apraxic patient often cannot perform complex motor tasks although he may show understanding by describing the task.

Apraxia, which may result from strokes in either side of the brain, is a complex problem, the pathophysiology of which is not yet completely understood.<sup>3</sup> What is clear is that apraxia in its various forms often results in rehabilitation difficulties for the patient.

The apraxic patient typically is unable to follow broad commands such as "get out of bed now" or "put on your dressing gown". He will often do much better if asked to do one specific act at a time, such as "roll over to me", "put your legs over this side of the bed", etc. Verbal instructions are not always sufficient; however, the patient may be able to perform the activity if the nurse demonstrates it or physically guides him through it one or more times while repeating the instruction. Sometimes just starting the sequence of movements, such as putting one arm in his shirt sleeve, will be enough to trigger the rest of the sequence.

#### **Time**

A stroke can also cause distortions in perception of time. Awareness of this fact helps a nurse to understand that the patient is not necessarily confused or intentionally a trouble-maker when he tells his wife, "I haven't eaten all day", or "They left me in a wet bed all night." Frequent verbal reminders of the time of day can be helpful, as can a bedside clock, if the patient has no problems with visual perception that prevent him from understanding it.

#### **The family**

If nurses have difficulty understanding the impact of perceptual distortion on a patient's behavior, it is easy to realize that he and his family may be even more confused and upset by the bizarre behavior for which there is no apparent cause. It is possible too that if the patient's family is not aware of disabilities such as vertical distortion or problems judging distance, they will not understand that there are situations in which he could easily injure himself, both in hospital and later at home.

Hopefully, the effort a nurse makes to understand what is happening to her patient, to learn how to help him cope with his disabilities and to share her knowledge with his family will have a positive effect on the family's understanding and commitment to have him improve and return home. ❖



# STROKE:

## A Review

Jane Bock

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**Geraldine Hart** is an assistant professor at the Dalhousie University School of Nursing where she teaches rehabilitation nursing. She is a graduate of the Victoria General Hospital School of Nursing in Halifax and obtained her BN from McGill University, followed by an MSN at the University of British Columbia. Most of her clinical nursing experience has been in neurological and neurosurgical nursing, and she spent eight years working at the Montreal Neurological Hospital.

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Apoplexy. Stroke. Cerebral vascular accident or CVA. Whatever you or your patients call it, stroke remains one of the leading causes of death in Canada. A CVA can have a devastating effect on an individual's life — of all CVA victims, about 50 per cent recover with little or no deficit, but the other 50 per cent require some form of continuous care for the rest of their lives.

Any individual case involves one of three causes of CVA:

- cerebral hemorrhage
- cerebral thrombosis
- atherosclerosis of arteries in the head or neck.

Regardless of the specific cause, what happens is that the flow of blood to the brain tissue is interrupted or reduced drastically, resulting in ischemia and the destruction of brain cells which, in turn, results in certain neurological deficits.

A CVA resulting from cerebral thrombosis can occur in any vessel in the brain but most often in the middle cerebral artery or one of its branches; the infarction stimulates an inflammatory response which leads to cerebral edema and the resulting occlusion of the artery.

Symptoms depend on the actual cause of the CVA, on the specific area of the brain involved, and the size of the affected area. Hemiplegia is the most common result; others are aphasia, memory loss and various neurological symptoms.

There are several factors which are thought to influence the incidence of CVA: high blood pressure, endocarditis or other cardiac disease, atherosclerosis, and poor health habits such as heavy smoking or drinking.

The severity of signs of stroke varies from individual to individual, but commonly seen are dizziness, headache, blurring of vision and black-out. The CVA victim may complain of a severe headache which is then followed by loss of muscular function and loss of consciousness. It has been noted that patients who are in a deep coma when admitted to hospital, or who remain in a coma for 24 to 36 hours have a grave prognosis. One might also see convulsive movements in the patient, or nausea and vomiting. Respirations may be slow, or even Cheyne-Stokes; the pulse will be slow but bounding.

The short term goal in treating the CVA patient is to get him through the initial or acute phase. This requires monitoring vital signs, and assessing the extent of any damage. Tests that may be done include physical examination, chest and skull x-rays, and other neurological tests such as brain scan, cerebral angiogram, EEG or CT scan.

Patients are usually nursed in the semi-prone or lateral position, and, depending on the degree of muscular deficit, may require total care such as feeding, turning, bathing, etc. An important goal of nursing care, after assessing the damage that has been done by the stroke, is to preserve existing function in the patient and work toward rehabilitation.

Complications can obstruct the patient's road to rehabilitation and return to his normal life: the post-CVA patient may have various deficits such as aphasia (of which there are several types), dysphagia, loss of memory, poor comprehension ability and various perceptual disorders. The most common visual defect is *homonymous hemianopsia* (loss of either the right or left field of vision in each eye). A common misconception among both nurses and the patients' families is that patients suffering from aphasia are not able to understand what is said to them: while both receptive and expressive capacities may be affected, they may not be altered to the same degree.

Most post-CVA recovery occurs in the first six months, and care should therefore be geared to returning the patient to normal function and self-care during this period. Poor nursing care can result in thrombophlebitis, hypostatic pneumonia, muscle atrophy, contractures, decubiti and sensory deprivation.

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# Health around the world

Maureen Johnson

## Reality in the Third World

is...*underweight* (babies that weigh less than 5.5 pounds at birth)...*malnutrition* that causes blindness among children...*starvation* that ends in death for two-year-olds. This is the kind of reality that only a handful of North American nurses will ever experience firsthand but all of us have wondered about it. We have worked with, grown up with, gone to school with nurses who have taken that big step — left their practice in Canada to work among the underprivileged people of the Third World.

Many, if not most of these nurses, have found jobs through CUSO (Canadian University Services Overseas). This national, nondenominational coordinating agency presently has more than 600 volunteers working on two-year contracts in health, agriculture, technology, business and education in Africa, Asia, the South Pacific, the Caribbean and Latin America.

What happens when you become a CUSO volunteer? To give you an idea, we present the experience of two nurses who served with CUSO in Sierra Leone and in Columbia.

Debbie Grisdale grew up in a comfortable, supportive Canadian home. After graduation from nursing school she worked in pediatric nursing and then in public health nursing in three Edmonton public schools. Two years ago she found herself thrust into a totally different environment — an isolated coastal town in Columbia, South America, where children die of malnutrition, diarrhea, tuberculosis and other respiratory diseases, where there is little work available for the 90,000 inhabitants, where there is no potable water and where electricity is available only spasmodically.

After travelling in Europe for three months and finding that she enjoyed meeting people and learning about their cultures, Debbie had decided that she wanted to experience a different lifestyle more fully by actually living in a different milieu; with this in mind, she applied to CUSO.

Debbie was assigned to Tumaco, Columbia to work with an agency which provides sponsorship by individual Canadians of needy children and their families in developing countries. CUSO paid her travel costs, medical, dental and life insurance coverage, and costs of orientation and language training. The employing agency paid her salary at local rates and housing was provided.

After a ten-week course in Spanish, Debbie joined another CUSO volunteer, a social worker, in Tumaco. Both young women had been warned that Tumaco would not be an easy place to work because of the extreme poverty; and initially they found it lonely as well. There were only four expatriates in Tumaco, the bulk of the population being of African descent, brought over to work as slaves in the gold mines in Columbia's interior. Upon gaining their freedom they gravitated to

the coast where they settled. The remoteness of this coastal area (it is 12 hours by dirt road from the nearest major center, 300 km away) had resulted in many years of neglect by the central government.

While most of the people in Tumaco exist by fishing, much of the fish is exported or sent to the Columbian interior. "The people live with fish on their doorstep yet it is so very expensive" remarked Debbie. "The majority of the time the women are left alone with the children. The birthrate is very high — and so is the deathrate. A woman might have eight or nine pregnancies but only four or five children living. Conditions are deplorable; people live in crowded, wooden shacks; some of them on stilts over the mudflats, and the only sewage system is the tide which carries the sewage out with it. Nutrition is poor because of the lack of money and the lack of knowledge; the diet is mainly rice, plantain and fish, when it is available. The conditions provide amazing potential for disease." Most cooking is done over open fires, candles are used for lighting as the electricity supply is unreliable, and during the two rainy seasons, most of the roofs leak.

As 90 per cent of the children in the town suffer from malnutrition, a program was organized in conjunction with the Columbian government to provide a daily lunch of salad, protein (beans, lentils or fish), vegetables, fruit and a glass of juice or nutritious drink for each child. Debbie worked with this program and the 500 children involved, who were checked monthly for changes in height, weight and for parasites — intestinal worms and amoebae are rampant because the need to boil drinking water for 20 minutes is often ignored.

Debbie worked in the agency's outpatient clinic which was set up mainly to treat sponsored children and their families but also gives aid to local needy people. On staff at the clinic are three Columbian doctors, two auxiliaries, eight aides plus a CUSO nurse. Patients pay five pesos (12 cents) per visit and are given their drugs free of charge. As well as curative medicine, the clinic is involved in preventive medicine; there is a prenatal program, a well-child clinic, vaccination and nutrition projects and control programs for tuberculosis and communicable diseases. Laboratory services are also provided.

Debbie was responsible for starting the prenatal, well-child and TB programs. "I also did some primary care for a couple of hours each day as the doctors didn't have time to see everybody," she recalls. "The work was never dull, and was quite different to the work I'd done in Edmonton where I found I got bogged down with paperwork and forms to fill in."

The most common problems seen at the clinic were diarrhea, respiratory diseases, pneumonia and tuberculosis. Among the malnourished children, diarrhea often led to dehydration and death. There was also an epidemic of red measles in Tumaco during Debbie's two years there. "We lost a lot of kids," she remembers. "It's a killer for the malnourished child."





"It is a challenging and exciting job with plenty of opportunities for creativity," she says. "Our students (most of whom are males) are directly involved in working with the community health program which is beginning to extend to all sections of our chiefdom (similar to a county in Canada)...The community health program really knows no limits here where the infant mortality rate is greater than 50 per cent, children die of measles, tetanus and malnutrition, polio victims are a common sight, traditional bone-setters, witch doctors and herbalists provide a major portion of health care, and taboos — such as mothers not feeding their children fish because they believe the children will get worms if they do — are common."

"It is surprising how quickly one adjusts to so many situations and changes — all part of adjusting to a new culture," she says. "How can one describe the experience of teaching five traditional midwives in a small village hut the principles of sterile technique, of seeing an entire school of primary school children marching through a village announcing an under-five clinic in song, or of riding in the back of a

"I feel very fortunate to be here. It seems that public health is the ideal job for getting to know the culture and the people of any area. As with health programs anywhere in the world, particularly community health, progress is slow. However, it is taking place and who can deny the signs of development one sees such as a mother learning to feed her child nutritious foods and passing that information to others, or of a health committee building 17 latrines and numerous refuse pits in a village which had none before." ♡

Capeling, Sharon, Editorial,  
*CUSO Forum* 1:2:2, Autumn,  
1979.

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# YOU AND THE LAW

## Hospitals and nurses: the evolution of legal responsibility

Corinne Sklar



Previous columns have indicated that hospitals are vicariously responsible in law for the negligence of their employees, servants and agents acting within the scope of their employment. This doctrine of "respondeat superior" (let the master answer) is not limited to hospitals: it applies generally to the master-servant (employer-employee) relationship wherever it may arise. However, the application of this doctrine with respect to the professional employees of a hospital (physicians and nurses) has until recently, had in the past special and limiting treatment by Courts. The trend in recent years has become to expand the hospital's legal responsibility for the conduct of professional employees, as exemplified by the recent decision of Mr. Justice Holland in the Ontario case *Yepremian v Scarborough General Hospital*.<sup>1</sup> That decision and a consideration of the hospital's legal responsibility for physicians was discussed in February, 1980.<sup>2</sup>

Is the hospital where you work legally responsible for any negligence committed in the performance of your professional duties? Allocation of legal responsibility is important for it determines who will compensate the patient for loss or harm. In general, the doctrine of the master's legal responsibility for the wrongful acts of his employees arises because the employee is considered to act on behalf of the employer as part of the

employer's enterprise. In addition, because the employer "controls" the conduct of the employee, he ought to act to prevent his employee's negligence. The employee acts upon the instruction of the employer and for his benefit. The employer is in a better position financially to compensate an injured party for his loss or damage.<sup>3</sup> The viability of this approach in a commercial or industrial situation is clear, but its application in the hospital context has been limited historically. The patient had to seek financial redress not from the hospital as the employer but from the professional staff member whose wrong had caused his loss or damage.

The earliest hospitals were charitable institutions (usually denominational) where the impoverished, the infirm and the incompetent received medical and nursing care. The nursing profession's development was rooted in the delivery of nursing care to patients on a charitable basis. At the turn of the twentieth century, hospitals were charged with the legal responsibility of providing facilities for patient care, as well as obtaining competent professional staff, both medical and nursing. A hospital had sufficiently discharged its legal responsibility to the patient if due care was taken to select and hire competent professionals to deliver patient care.

Thus if the negligence of a professional resulted in loss or injury to the patient, the hospital, having taken due care in selecting the professional, was relieved of any legal responsibility to compensate the patient for his loss or damage. The professional, if sued and found liable, had to compensate the patient. Hospitals were legally responsible for loss or damage resulting from the negligent acts or omissions of their non-professional employees such as cleaning staff and kitchen personnel under the master-servant doctrine as was any employer. This position was sustained as hospitals shed their charitable image and became the precursor of the complex health care facility we know today.

The protection of a hospital from legal liability to patients because of its charitable status was not well developed in Britain and Canada although the doctrine of charitable immunity became well entrenched in the United States and as a result, the vicarious responsibility of hospitals in American law has taken a different course. Even in the U.S., however, the thrust of modern judicial interpretation today has eroded this doctrine so that it is now rapidly

disappearing; modern concepts of legal responsibility and the increasing use of insurance have been instrumental in reducing the applicability of the charitable immunity rule. Thus the rule of respondeat superior applies increasingly to both private and charitable American health institutions.

### *The "Administrative-Professional" Dichotomy*

The famous 1909 English case, *Hillyer v St. Bartholomew's Hospital*,<sup>4</sup> influenced the development of the law in this area. The court held that a hospital's legal responsibility was limited to the selection of competent medical staff and to furnishing proper facilities and equipment. A hospital was vicariously responsible only for negligent acts of professionals in the exercise of ministerial or administrative duties and not for the negligent acts of professionals if these acts occurred in the exercise of their professional skills. The reasoning was that hospitals could not control a professional in the exercise of professional duties. Where a nurse's act was alleged to have caused the harm, courts had to classify the nurse's action as either "routine" or "administrative" or as "professional" in order to determine the hospital's liability.

### *The Borrowed Servant Rule*

The Borrowed Servant rule was that the nurse passed out of the control of the hospital authority when she moved under the control, supervision and authority of the physician. Once the nurse passed out of the hospital's control, it was not responsible in law for

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her wrongful acts. This rule was applied most commonly in the operating room where the surgeon was considered "Captain of the Ship" and the members of the O.R. nursing staff were held to be directly under his control and supervision. This view was also expressed in the Hillyer case. Thus, the case law considered both the administrative vs professional dichotomy and whether the nurse was exercising her duties under the express control of the physician. These were the important determinants in the development of the law of hospital responsibility. Today none of these aspects applies however to hospital liability.

#### The Case Law

In *Lavere v Smith's Falls Public Hospital*,<sup>5</sup> a 1915 case, a hospital was held responsible for the burns suffered by the patient. The nurse was not sued personally by the patient. The patient had had surgery and while still under the effects of the anesthetic, she suffered a severe burn on her heel. The nurse had placed an overheated brick in the bed to warm it. The court found that such action was a routine duty performed by nurses. The nurse was not acting under the supervision of the surgeon but was carrying out her routine duties as a hospital employee. The court rejected the argument that as a charitable institution the hospital was immune from legal liability for this negligence.

In *Nyberg v Provost Municipal Hospital*,<sup>6</sup> a 1926 case, the Supreme Court of Canada found the hospital liable for the negligence of a nurse who caused the patient to be burned by misapplying a hot water bottle postoperatively. This decision reversed the Alberta Court of Appeal's decision which had absolved the hospital of responsibility.

The Supreme Court found again that the application of heat was a routine duty performed by nurses in their ward management. The hospital was liable notwithstanding that the nurse had applied the hot water bottle in the presence of the O.R. surgeons. The majority of the Court found that here the nurse was not under the control of the physicians who had not ordered the treatment.

In a 1937 Ontario case,<sup>7</sup> the hospital was relieved of liability to the patient who had been admitted with a puerperal infection. The surgeon ordered the application of heat by means of a heat cradle which operated with six light bulbs. The patient was severely burned. The plaintiffs sued only the hospital and were denied recovery.

The Court found that the nurse was performing a professional skill at the order of the physician and thereby was under his direction and control. Because she was carrying out the express instruction of a physician, she was exercising professional knowledge and skill and not performing a routine responsibility. The nurse was acting professionally in determining the

number of bulbs to be used in the cradle. The hospital had "loaned" the nurse to the doctor as a trained assistant exercising professional skills as a nurse. Thus the misapplication of a heat apparatus seems to have forced the Court to distinguish between heat as a specific treatment and heat as a routine nursing care matter. The appropriate nursing care principles in applying heat to a patient are the same for any heat application.

One year later, in 1938,<sup>8</sup> the Supreme Court of Canada found a hospital liable for a nurse's negligence in applying diathermy treatment to a patient on the express order of the physician. Again the patient was badly burned. Here the physician simply ordered the treatment with no detailed instructions. The nurse was a hospital employee who specifically acted as the technician in administering this treatment to the hospital's patients. The Court did not engage in the administrative vs professional dichotomy. Significantly, the Court focused on the basic relationship of employment and found the nurse to be the employee of the hospital and not the assistant of the physician. Why was the nurse not considered "a professional exercising a professional skill?" It would appear that nurses were not viewed as independent professionals. Instead, they were viewed as exercising professional nursing skills only under the instruction of physicians! This Supreme Court decision heralded significant changes in the law that resulted from the following English cases.

In 1942, the English Court of Appeal in the case of *Gold v Essex County Council*<sup>9</sup> dramatically altered its position with respect to hospital responsibility. The Court found that a public hospital is liable for the negligence of a physician employed by it even though the physician is acting professionally in the exercise of medical skill and knowledge. In later cases (1951 and 1954) hospital responsibility for the negligence of physicians paid by the hospital, whether as full time employees or not, was sustained and expanded. In regard to nurses, two cases illustrate the shift in judicial view.

In *Winn v Alexander*, [1940] O.W.N. 238, a sponge left inside the patient was discovered on subsequent surgery. The hospital was not held responsible because when a nurse enters the operating room to assist the surgeon, she passes out of the hospital's control and is fully under the charge of the surgeon.

In 1955, in *Petite v MacLeod*,<sup>10</sup> the Court took a different view. Here a sponge again was found in the patient's body after surgery. The patient had had several abdominal operations previously. The O.R. nurses of the defendant hospital had found the sponge count to be accurate in the surgery under scrutiny. The Court looked at the relationship between the nurses, the doctor and the hospital. The Court's finding was that hospitals are liable for the negligence of employees be they

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Day 0 Infected, heavily exudating decubitus ulcer on left hip.



Day 2 Exudate diminished. Erythema and edema reduced.



Day 14 Clear, healthy granulation base; grafted successfully.



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Day 4 Clear, healthy granulation base.



Day 14 Ulcer healing after Debrisan discontinued.



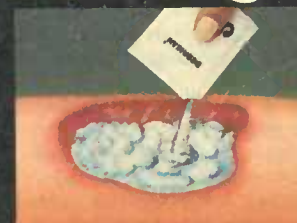
Day 0 Undermined sacral decubitus ulcer infected with *Pseudomonas* and *E.coli*.



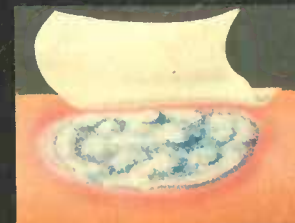
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nurses or physicians acting in the course of their employment. The Court stated that a nurse's employer is legally responsible for the negligence of a nurse in her execution of a physician's order as part of her routine nursing duties. The Court expressly found that there was no difference between professional and non-professional acts.

Modern hospital law is no longer burdened with the artificial considerations of the Borrowed Servant rule and the professional vs administrative dichotomy. The needs and rights of the public to the delivery of safe and competent nursing care in hospital dictate that hospitals cannot discharge their legal responsibility solely by hiring competent nursing staff. Today, hospitals have a duty to control, supervise and maintain nursing care at a quality standard. Nurses have the legal responsibility to exercise their professional knowledge and skill according to the standard of care required of professional nurses. If the standard of care is not met and a patient suffers loss or damage, a hospital is vicariously liable for the negligence of its staff nurses acting in the scope of their employment and will have to compensate the patient in accordance with the determination of a Court.

We have come a long way from the tortuous judicial route set out in this area of law in the early 1900's. That the law can and does change to meet the different and important needs of society in changing times is clear. The law of hospital responsibility illustrates both how the law changes and how nursing practice has been part of this growth.

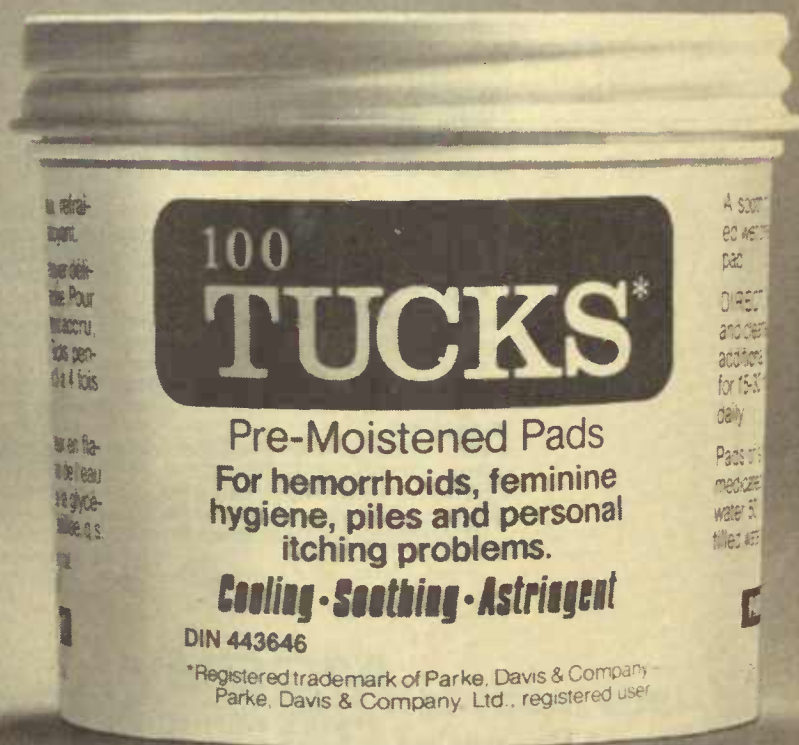
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- \*10 [1955] 1 D.L.R. 147 (N.S.S.C.).

\*Unable to verify in CNA Library

"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a recent graduate of the University of Toronto Faculty of Law. Prior to entering law school, she obtained her BScN and MS degrees in nursing from the University of Toronto and University of Michigan.

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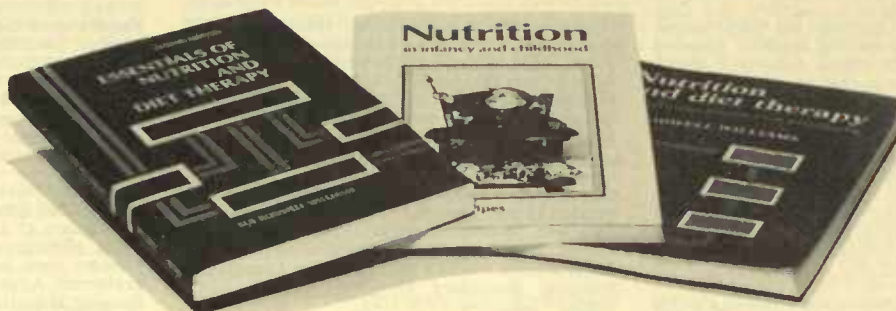
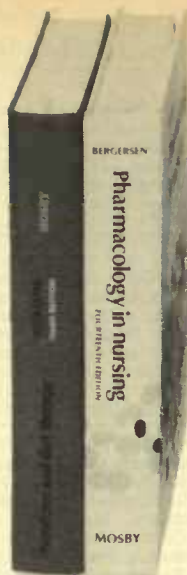
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**General Duty Nurses** - Must be registered with RNABC. Salary according to the RNABC Agreement. Please apply to: Mrs. A. Houghton, R.N., Director of Nursing, Fort St. John General Hospital, 9636-100th Avenue, Fort St. John, British Columbia V1J 1Y3.

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**Registered Nurses** required immediately for permanent full time positions at 10-bed hospital in B.C. Salary at 1978 RNABC rate plus northern living allowance. Recognition of advanced or primary care education. One year experience preferred. Apply: Director of Nursing, Stewart General Hospital, Box 8, Stewart, British Columbia V0T 1W0. Telephone: (604) 636-2221 Collect.

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For further information write to:

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**Miscellaneous**

Post-ICN Conference at UCSF School of Nursing. The University of California, San Francisco, School of Nursing, (only one-hour flight away from ICN location) announces an international conference focused on: Nursing's Influence on the Health of Families; University of California, San Francisco, July 7, 1981 (CE credit offered) For more information, contact: Margretta M. Styles, Dean and Professor, School of Nursing, N319Y, UCSF, San Francisco, California 94143, USA.

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**Registered Nurses**

Opportunities for nurses interested in working as members of the interprofessional team in the new 240 bed Acute Care Unit, of the H.S.C. on the U.B.C. campus.

Positions available in:

- Operating Room Suite
- Intensive/Coronary Care
- Medicine
- Surgery
- Emergency

Nurses must be registered or eligible for registration with the RNABC.

Applicants should apply in writing with detailed resume to:

Coordinator of Professional Employment  
Health Sciences Centre  
University of British Columbia  
Vancouver, B.C.  
V6T 1W5

Positions open to both female and male applicants.

**Royal Alexandra Hospital**

This 932 bed active treatment hospital invites applications from nurses across Canada.

We offer experience in all areas of patient care including intensive care, neonatal intensive care and obstetrical perinatology. The extended work day and compressed work week is currently in effect in the Intensive Care areas.

Applicants must be eligible for registration with the Alberta Association of Registered Nurses.

Please direct inquiries to:

Personnel Officer  
Nursing Recruitment  
Royal Alexandra Hospital  
10240- Kingsway Avenue  
Edmonton, Alberta  
T5H 3V9



## Interested in a Challenge? Try International Nursing - in Saudi Arabia!

The King Faisal Specialist Hospital and Research Centre, a 250 bed Acute Care Referral facility in Riyadh, Saudi Arabia, has current and/or periodic openings for experienced R.N.'s. Managed by the Hospital Corporation of America Group, the hospital is staffed with professionals from North America, Europe and the Middle East.

The Nursing Areas currently available are: NICU, L & D, PEDS, INSERVICE, CLINIC & RADIATION THERAPY. Requirements include three years current experience as an R.N. in an Acute Care hospital with at least one year in the specialty and a current R.N. license in one of the provinces. Verbal and written fluency in English. 2-Year contract commitment. Positions are single status.

Salaries are excellent and the exceptional benefits include 30 days paid annual leave, free transportation, furnished lodging, bonus pay and leave and more.

If you are a dedicated professional with a desire to make a contribution — to experience the unusual — to travel — to work side-by-side with people from around the world — then we'd like to hear from you.

**Don't Let This Once In A Lifetime Opportunity Pass You By**

For further information please contact:

**Kathleen Langan, R.N.**  
**Hospital Corporation International, Ltd.**  
**Two Robert Speck Parkway Ste. 750**  
**Mississauga, Ontario L4Z 1H8**

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Please send me complete information on your nursing opportunities

CN 5/80



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**U.S. Nurse Recruiter**

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\* Without obligation, please send me more information and an Application Form.

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CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE ( ) \_\_\_\_\_  
LICENSES: \_\_\_\_\_  
SPECIALTY: \_\_\_\_\_  
YEAR GRADUATED: \_\_\_\_\_ STATE: \_\_\_\_\_

## Nursing in the Sunny Palm Beaches

Picture yourself in the sunny Palm Beaches working at the most prestigious hospital in Florida. Good Samaritan Hospital has maintained the tradition of being the first in the latest hospital services and facilities. Our good name and outstanding history attest to our success.

A 326 bed, J.C.A.H. accredited hospital offering attractive salaries and benefits including:

- Active in-service orientation
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- 5 day week
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- Education and experience differential
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- Seasonal employment welcome
- Patient-mix 90% under age 65

We will sponsor the appropriate employment Visa for qualified applicants. Attractive efficiency apartments available at far below commercial rates, overlooking the beautiful Lake Worth and located across the boulevard from the hospital.

Write:

Director of Personnel (305) 655-5511  
Good Samaritan Hospital  
Flagler Drive at Palm Beach Lakes Blvd.  
P.O. Box 3166  
West Palm Beach, Fla. 33402

## OPPORTUNITY

**Alberta**

### Clinical Nurse Specialist - Ponoka

You will serve as consultant on patient care nursing diagnosis, Health Care standards, improving quality of care as it relates to human relations, and by research, developing and testing new concepts and nursing theories.

Qualifications: Graduation from a recognized School of Nursing plus considerable related experience, including consultative experience. Must be eligible for registration in an Alberta Association. Baccalaureate or Master's Degree in Mental Health and/or Behavioural Sciences preferred. Equivalencies considered.

Salary: \$18,024 - \$22,596

Competition #9212-4 Open until suitable candidate selected.

Apply to:

Personnel Director  
Alberta Hospital  
Box 1000  
Ponoka, Alberta  
T0C 2H0

## Educational Opportunities

### 1. B.N. Degree Programmes

- (a) Basic Students
- (b) R.N.'s

### 2. Degree or Diploma Program in Outpost Nursing and Nurse-Midwifery

### 3. Diploma Programmes

- (a) Community Health Nursing
- (b) Mental Health and  
Psychiatric Nursing

Send applications to:

Mr. W. Brake  
Admissions Committee  
School of Nursing  
Memorial University of  
Newfoundland  
St. John's, Newfoundland  
A1C 5S7

## University of Jordan Faculty of Nursing

Faculty Position: Positions available for September 1980:

- Medical-Surgical-Nursing
- Pediatric Nursing
- Obstetric Nursing
- Community Nursing
- Psychiatric Nursing
- Nursing Administration, in  
Baccalaureate Program.

Doctorate degree is preferable but Master's degree with Clinical specialization and teaching experience is essential.

Salary and rank commensurate with educational preparation and experience.

Apply to:

President  
University of Jordan  
Amman - Jordan

## R.N.'s Required

Applications are invited for full time nurses to work rotating shifts in new 40 bed active treatment hospital. High level of activity in Emergency, Surgery and Obstetrics offers challenge and the benefit of valuable experience for conscientious nurses. Previous experience an asset. Must be registered or eligible for registration in Alberta.

AHA/AARN Policies in effect.

Hinton is a modern, progressive, industrial town on the eastern slopes of the Rockies, 50 miles east of Jasper. Population 7,600. Unlimited year round recreational facilities.

Apply with full resume including experience and references to:

Director of Nursing  
Hinton General Hospital  
Box 40  
Hinton, Alberta  
T0E 1B0

## Prince George Regional Hospital

Positions available for experienced nurses or nurses interested in developing their skills in specialty nursing — Operating Room, ICU/CCU, Neonatology Nursing. Must be eligible for B.C. Registration.

- Well developed orientation program
- Inservice Education
- Expanding Operating Room and Obstetrical Suite
- 10 bed ICU/CCU

Prince George Regional Hospital is a 340 bed acute regional referral hospital with a 75 bed extended care unit and has a planned program of expansion.

For further information contact the:

Personnel Department  
Prince George Regional Hospital  
2000 - 15th Avenue  
Prince George, British Columbia  
V2M 1S2



# Our nurses write better ads than we do!

Responsibility, pride, and changing attitudes, that's what Kaiser-Permanente nursing is all about. Our nurses are vital members of an expert medical care team and have worked hard in order to get where they are today. Kaiser-Permanente recognizes that today's nurse is a skilled professional and must be treated as such. We're seeing to it that our nurses are given every opportunity to explore and utilize their professional talents. But don't take our word for it, take it from someone who really knows... our nurses. "The responsibility is yours... as a nurse, you are it!"



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Our nine southern California Medical Centers have openings now for all levels of nursing. We invite you to join us and accept the challenge of professional nursing. For more information on any one of our 9 medical centers contact:



## Intensive Care Nurses

300 bed Accredited general hospital in Vancouver requires full-time R.N.s for 4 bed I.C.U. Candidates should be eligible for registration with the RNABC. Previous I.C.U. experience required.

Please apply in writing to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C. V5T 3N4



## Supervisor - Operating Room

Required to assume a leadership role in an expanding Operating Room Suite presently under construction with date of completion September 1980.

The applicant must have demonstrated leadership and administrative skills, post-graduate education in O.R. nursing and past experience as a Head Nurse or Supervisor.

Must be eligible for B.C. registration.

Prince George Regional Hospital is a 340 bed acute Regional Referral Hospital located in Central B.C.

Qualified applicants are invited to submit their resumes to:

Assistant Executive Director,  
Patient Services  
Prince George Regional Hospital  
2000 - 15th Avenue  
Prince George, B.C. V2M 1S2

## Summer Employment

### Registered Nurses

Nursing opportunities will be available for a 3 or 4 month period during the months of May, June, July, August 1980. Nurses will provide primary nursing care, be able to exercise clinical judgement and participate in a patient-family oriented program in our modern 300 bed teaching extended care unit. Interested nurses, who are eligible for registration in British Columbia should write to:

Hospital Employment Officer  
Health Sciences Centre Hospital  
University of British Columbia  
Vancouver, B.C.  
V6T 1W5

Positions open to both female and male applicants.

## Royal Inland Hospital Kamloops, B.C. Registered Nurses

Applications are invited for staff additions to Medical-Surgical Nursing, Psychiatric, Intensive Care, Obstetrics, Rehab Unit and Neuro Services.

- 400 bed accredited acute care referral hospital.
- active inservice programmes with Clinical Instructors for staff development.
- 1979 salary (\$1305 - 1542 per month). 1980 being negotiated.
- benefits as per R.N.A.B.C. contract.
- extended and regular hour shift rotations.
- eligibility for B.C. registration essential.

Apply to:  
Personnel Director  
Royal Inland Hospital  
311 Columbia Street  
Kamloops, B.C. V2C 2T1

## Royal Jubilee Hospital Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

## School of Nursing Nursing Instructors

required for August, 1980  
in a 2 year English language  
Nursing Diploma program

**Qualifications:**  
Bachelor of Nursing with experience in Teaching and at least one (1) year in a Nursing Service position, courses in Teaching Methods and eligible for registration in New Brunswick.

Apply to:

Harriett Hayes  
Director  
The Miss A.J. MacMaster  
School of Nursing  
100 Arden St.  
Moncton, N.B.  
E1C 4B7  
Telephone: 506-854-7330

## Post Graduate Training in Operating Room Technique and Management

Applications are now being accepted. This programme will begin in early September and has a duration of twenty-six weeks.

For further information and application forms please write to:

Supervisor of Operating Room /  
Recovery Room  
Hotel Dieu Hospital  
Kingston, Ontario  
K7L 3H6  
Canada

## Supervisor in Public Health Nursing

Supervisor in Public Health Nursing for the Middlesex-London District Health Unit for August-September 1980.

Challenging position in progressive agency covering a rural and urban population of over 300,000.

Program administration responsibility as well as staff supervision.

**Qualifications:**  
B.Sc.N. degree currently registered in Ontario with at least five years public health nursing experience. Those with advanced degrees and experience in supervision will be given preference.

Excellent fringe benefits.

Salary Range: \$20,432 to \$23,710.

A curriculum vitae should be submitted to:

Mrs. Dorothy M. Mumby, B.Sc.N., M.A.  
Director of Public Health Nursing  
Middlesex-London District Health Unit  
346 South Street  
London, Ontario  
N6B 1B9

## McMaster University Educational Program For Nurses In Primary Care

McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

**Requirements** Current Canadian Registration. Preceptorship from a medical practitioner. At least one year of work experience, preferably in primary care.

For further information write to:  
Mona Callin, Director  
Educational Program for Nurses  
in Primary Care  
Faculty of Health Sciences  
McMaster University  
Hamilton, Ontario L8S 4J9



## RED DEER REGIONAL HOSPITAL CENTRE REQUIRES NURSES



With close proximity to the beautiful Rocky Mountains, along with fine cultural and excellent recreational facilities, we present to you our City of Red Deer. Midway between Edmonton and Calgary thrives our City of 40,000.

Our Regional Hospital Centre is a rapidly expanding multi-institutional hospital located in Red Deer. The Centre will encompass 630 active treatment and Extended Care beds and is projected to activate its new expanded facilities by early fall of this year.

We require:

Head Nurses  
Teaching Assistant Head Nurses  
Staff Nurses

to complement our nursing staff for the centre. Our Personnel Department is presently accepting applications for these positions. Applicants with general medical and surgical experience are preferred. Also, a Bachelor of Science degree in Nursing would be desirable.

**If interested in these or any other hospital related positions please call  
Bob King, Personnel Co-ordinator  
at (403) 343-4585 or write  
"Nursing Opportunities", Personnel  
Department, Red Deer Regional Hospital  
Centre, 3942 - 50A Avenue,  
Red Deer, Alberta, T4N 4E7**



## OPPORTUNITY

Alberta

### Community Mental Health Nurse - Red Deer

90 miles from Calgary/Edmonton

Functioning as a primary therapist, you will assess and treat complex disorders of thought behaviour and emotions; public education and community development. Backed up by inter-disciplinary team resources, excellent opportunities are provided for professional growth, orientation and staff development.

Qualifications: B.Sc.N. preferred, but R.N. or R.P.N. with experience will be considered. Must be eligible for registration with approved Association(s) in Alberta.  
NOTE: Automobile is required.

Salary: \$14,748 - \$17,340  
Competition #9176-3 Open until suitable candidate selected.

For detailed information, request Job Bulletins and apply to:

Alberta Government Employment Office  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4

## MANIT<sup>BA</sup>

### Director of Nursing Services

The Department of Health, Institutional Services, Brandon Mental Health Centre, requires a person for this senior administrative position wherein the incumbent is responsible for planning and directing the delivery of Nursing Services in a large Mental Health Centre. Responsibilities include planning, directing and evaluating patient care programs, staff recruitment and development, and all related activities designed to ensure high standards of nursing practice.

B.N. and significant related Psychiatric Nursing and administrative experience at a senior level. Equivalent combinations of training and experience may be considered.

Salary Range: \$20,876 - \$25,569 per annum

Apply in writing immediately:

Civil Service Commission  
904 - 155 Carlton Street  
Winnipeg, Manitoba R3C 3H8

Competition No. CN/66

### Director of Professional Services

Applications are invited for the position of Director of Professional Services, Canadian Nurses Association, Ottawa, Ontario.

Candidates must be members of the Canadian Nurses Association, have a master's degree or equivalent and have had at least five years' administrative experience. A working knowledge of both official languages is required.

Interested applicants are asked to submit their curriculum vitae, in confidence, to:

Executive Director  
Canadian Nurses Association  
50 The Driveway  
Ottawa, Ontario  
K2P 1E2



**DEPARTMENT OF COMMUNITY  
SERVICES AND CORRECTIONS****Regional Co-Ordinator  
Public Health Nursing - Winnipeg**

A suitably qualified and experienced public health nurse is required for the above position

Responsibilities include planning, co-ordinating and evaluation of comprehensive public health nursing programs for the Winnipeg Region.

Candidates should preferably possess a M.Sc.N. supplemented by several years' progressively responsible related experience and be eligible for licensure with M.A.R.N.

Salary range up to \$29,480 per annum commensurate with qualifications.

Apply immediately quoting Competition #1020 to:

Department of Community Services and Corrections  
Personnel Management Services Branch  
270 Osborne Street N.  
Winnipeg, Manitoba  
R3C 0V8

**Registered Nurses/Psychiatric Nurses  
- Ponoka**

The Alberta Hospital, a dynamic regional centre with a 3 year accreditation status, requires nursing staff for general and psychiatric treatment duties. We offer a nurses' residence with attractive staff facilities, twelve (12) paid holidays, three (3) weeks annual vacation (4 weeks after 10 years service), and a very attractive benefit package; including uniforms, laundry and free parking.

Qualifications: Graduation from an approved school of Nursing. Must be eligible for registration with the respective professional Alberta Association. NOTE: Shift work involved.

Salary: \$14,748 - \$17,340

Competition #9176-2 Open until suitable candidates selected.

For detailed information, request Job Bulletins and apply to:

Alberta Government Employment Office  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4

**G.F. Strong Rehabilitation Centre  
Vancouver, British Columbia****Registered Nurses - Nursing  
Supervisors**

If you are interested in Primary Nursing in a modern rehab setting, we will be opening a new 50-bed floor soon and have full time vacancies for B.C. Registered Nurses and Shift Supervisors.

We treat patients with severe disabilities, paraplegia, quadraplegia from spinal cord injuries, arthritis, amputations, head injuries, M.S. and other chronic neurological conditions.

Salary and benefits according to RNABC Agreement.

Please apply to:

Personnel  
G.F. Strong Rehabilitation Centre  
4255 Laurel Street  
Vancouver, B.C.  
V5Z 2G9  
734-1313

**High Risk Obstetrics and Neonatal  
Intensive Care Nurses**

Chedoke-McMaster Hospital - McMaster Division is a progressive teaching hospital with a multi-disciplinary team approach to patient care. Major specialties include Obstetrical Intensive Care and Neonatal Intensive Care units. When openings occur in these areas for Registered Nurses, we require experienced Staff. Inquiries are welcomed at any time from mature, responsible individuals who wish to work in a stimulating environment on a 12 hour shift system. Preliminary interviews can be arranged for out-of-town nurses eligible for Ontario registration if written requests are accompanied by detailed resumes. Nurses with related Critical Care backgrounds may be considered for training.

Please apply to:

Ms. N. Prosser, Personnel Interviewer  
Chedoke-McMaster Hospital  
McMaster Division  
Box 2000, Station "A"  
Hamilton, Ontario  
L8N 4Z5



## Director of Nursing

The Edmonton Health Department will require around August 1, 1980, a Director of Nursing to replace Miss Evelyn Crookshanks who is retiring.

The Department serves a population of 500,000 with a comprehensive range of public health services; staff in the Nursing Division number 160 and there are seven program areas for which the Director is currently responsible.

Formal qualifications should preferably include wide experience in public health in field and administrative settings and a Master's degree. Other qualities sought are the ability to think, plan and communicate effectively, to provide dynamic leadership, to assess critically yet objectively and to cooperate harmoniously with other agencies.

Please write enclosing a full curriculum vitae to:

**Dr. J. M. Howell**  
Medical Officer of Health  
City of Edmonton Health Department  
7th Floor CN Tower  
Edmonton, Alberta  
T5J 0K1

Further details are available from Miss Crookshanks at (403) 428-3640.

## Registered Nurses

Come to work in scenic Corner Brook!

Registered nurses are needed for this 350 bed Regional General Hospital, with detached 60 bed Special Care Unit, serving the West Coast of Newfoundland.

The hospital offers good fringe benefits such as four weeks annual vacation and eight statutory holidays plus birthday holiday. In addition there is a hospital pension plan and a group insurance plan for all permanent employees.

Accommodation and assistance with transportation is available.

Negotiated Salary Scale:

1 January, 1979 — \$12,771.00 — 15,429.00  
1 January, 1980 — \$13,410.00 — 16,199.00  
(Contract not yet signed)

Service Credits recognized.

Interested applicants apply to:

**Mrs. Shirley M. Dunphy**  
Director of Personnel  
Western Memorial Regional Hospital  
P.O. Box 2005  
Corner Brook, Newfoundland  
A2H 6J7



Open to both  
men and women



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## DIRECTOR OF NURSING SERVICE

Salary: \$18,554 — \$21,732 (under revision)

Plus \$1,000/yr Penitentiary Allowance

Ref. No: 80-PSC/CSC-OC-S227

Correctional Service of Canada, Regional Psychiatric Centre  
Saskatoon, Saskatchewan

A Director of Nursing Service is required for a 106 bed psychiatric hospital in Saskatoon, Saskatchewan responsible for the treatment of psychiatrically disturbed inmates of both provincial and federal institutions. This hospital is affiliated with the University of Saskatchewan, in particular the Departments of Psychiatry and Nursing. An active research department is part of the establishment and it is planned that the Centre will be used to train post-graduate students of many health care disciplines.

We require a Director of Nursing Service with considerable practical psychiatric nursing who is interested in accepting challenge and responsibility.

### Qualifications

This position carries with it a university appointment at the University of Saskatchewan in the College of Nursing. Candidates must possess as a minimum a Baccalaureate degree in nursing and registration as a registered nurse in a province or territory of Canada. Certification as a registered nurse will be considered an asset. Candidates must also possess acceptable psychiatric nursing experience and demonstrated competence in nursing service management and ability to provide expert professional advice in psychiatric nursing.

Knowledge of English is essential.

### Benefits

Excellent pension plan, good sick leave benefits; 11 statutory holidays; 3 weeks vacation to start; an excellent in-service training programme; plus relocation expenses paid. Hours of work: 37.5 hours per week.

*"Additional job information is available by writing to the address below;*

*Toute information relative à ce concours est disponible en français et peut être obtenue en écrivant à l'adresse suivante".*

**How to apply**

Send your application form and/or résumé to:

**Keith A. Sinclair, District Director**  
Public Service Commission of Canada  
1110 — 1867 Hamilton Street  
Regina, Saskatchewan S4P 2C2

*Please quote the applicable reference number at all times.*



# a little help



## can go a long way

...to the Canadian North in fact!

Canada's Indian and Eskimo peoples in the North need your help. Particularly if you are a Community Health Nurse (with public health preparation) who can carry more than the usual burden of responsibility. Hospital Nurses are needed too... there are never enough to go around.

And challenge isn't all you'll get either — because there are educational opportunities such as in-service training and some financial support for educational studies.

*For further information on Nursing opportunities in Canada's Northern Health Service, please write to:*

Medical Services Branch  
Department of National Health and Welfare  
Ottawa, Ontario K1A 0L3

Name .....

Address .....

City ..... Prov. ....



Health and Welfare  
Canada

Santé et Bien-être social  
Canada

## Director of Nursing

A challenging career opportunity is available for a dynamic innovative individual to direct and manage the department of nursing. The hospital has 518 beds and is a teaching hospital affiliated with Queen's University.

The successful applicant will possess B.Sc.N. with at least 5 years experience in a senior managerial position with demonstrated administrative skills in terms of budgetary, clinical and organizational concepts within the current health care system.

Apply in confidence submitting complete resume, including salary expectation to:

Director of Personnel  
Kingston General Hospital  
Stuart Street  
Kingston, Ontario  
K7L 2V7

## Assistant Director of Nursing

### Active Treatment

Required for a fully accredited 135 bed active care hospital.

#### The Position

As a member of the Nursing Administration Team, this nurse needs innovative qualities and ability to organize, delegate and direct the work of others. The applicant must have an enthusiasm for initiating and following up new ideas, projects and quality assurance programs.

#### Minimum Qualifications

Candidates must be currently registered in the Province of Alberta, and possess a Baccalaureate Degree in Nursing, with demonstrated competence and ability in a senior level nurse management position.

The position becomes available August 18, 1980, upon the retirement of the present incumbent.

Interested applicants may submit a comprehensive resume to:

Mr. Bruce Finkel, Director of Nursing  
Wetaskiwin General Hospital  
5505 - 50 Avenue  
Wetaskiwin, Alberta  
T9A 0T4



## A Completely Modern Teaching Hospital

### Requires

### Registered Nurses



This 500 bed general hospital is the major teaching facility for the Medical School of Memorial University of Newfoundland.

#### Services offered -

Critical Care, Medical, Surgical Coronary Care, General Surgery, Urology, Gynecology, Medicine, Nephrology, Clinical Teaching, Neurosciences, Cardiology, Cardiovascular Surgery, Orthopedics, Hemodialysis (kidney transplants), Emergency and Out Patient Services, active Rehabilitation Program (adult).

The Staff Development and Training Department offers ongoing lectures and demonstrations in addition to a 6 month diploma course (twice yearly) in — Critical Care Nursing, Neurosciences, Operating Room Nursing.

Located in St. John's, Newfoundland — the oldest city in North America with a population of 120,000, offering cultural and recreation activities in a friendly atmosphere.

Fishing, hunting, boating available approximately 10-14 miles outside the city.

For information regarding salary and relocation expenses and other conditions of employment write or call -

Miss Dorothy Mills  
Staffing Officer - Nursing  
The General Hospital  
Prince Philip Drive  
St. John's, Nfld.  
A1B 3V6

Telephone # (709) 737-6450

## Centracare Saint John Inc. Associate Director of Patient Care (Nursing)

This 500-bed hospital is seeking applications from creative nurse specialists seeking an opportunity to further their career. Centracare is affiliated with the Dalhousie University School of Medicine.

#### Qualifications:

Graduation from an approved School of Nursing with considerable related experience, including supervisory or consultative experience.

Must be eligible for registration in the New Brunswick Association of Registered Nurses. Post-Graduate preparation, preferably to the Baccalaureate or Masters level. Competence in English is essential.

#### Duties:

Acts as a **Counsellor** by assisting the Nursing team in Nursing Diagnosis and new care approaches.

Acts as an **Educator** in order to bring Health Care Standards to their optimal level.

Acts as a **Change Agent** to improve the quality of care by utilizing Skills and Theories of Human Relations.

Acts as a **Researcher** by utilizing valid research, findings for patient care and by contributing to Research activities in order to develop and test concepts on Nursing Theories.

Performs other duties as required.

Responsible to the Director of Nursing.

Salary: Negotiable

Apply to:

Personnel Office  
Centracare Saint John Inc.  
P.O. Box 3220  
Saint John, N.B.  
E2M 4H7

Competition Number CSJ 80-11

## OPPORTUNITY

# Alberta

### Nurses

Applications are invited for positions at Alberta Hospital, Edmonton, a 650 bed active treatment psychiatric hospital, located 4 km. outside of Edmonton.

Successful candidates must be graduates from a recognized School of Nursing and eligible for registration in their professional association; willing to work shifts. Vacancies exist in Admissions, Forensic, Rehabilitation, and Geriatric Services. Note: Transportation is available to and from Edmonton. Accommodation is available in the Staff Residence.

Salary \$1,229 — \$1,445 per month (Starting salary based on experience and education)

Competition #9184-9

This competition will remain open until a suitable candidate has been selected.

Qualified persons are invited to phone, write or submit applications to:

Personnel Administrator  
Alberta Hospital, Edmonton  
Box 307, Edmonton, Alberta  
T5J 2J7  
Telephone: (403) 973-2213



## Metro-Calgary and Rural General Hospital District #93

The Holy Cross Hospital, Rockyview Hospital and the Colonel Belcher Hospital invite applications from R.N.'s for positions in all areas.

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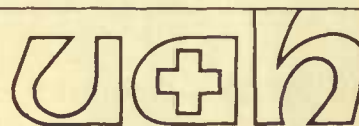
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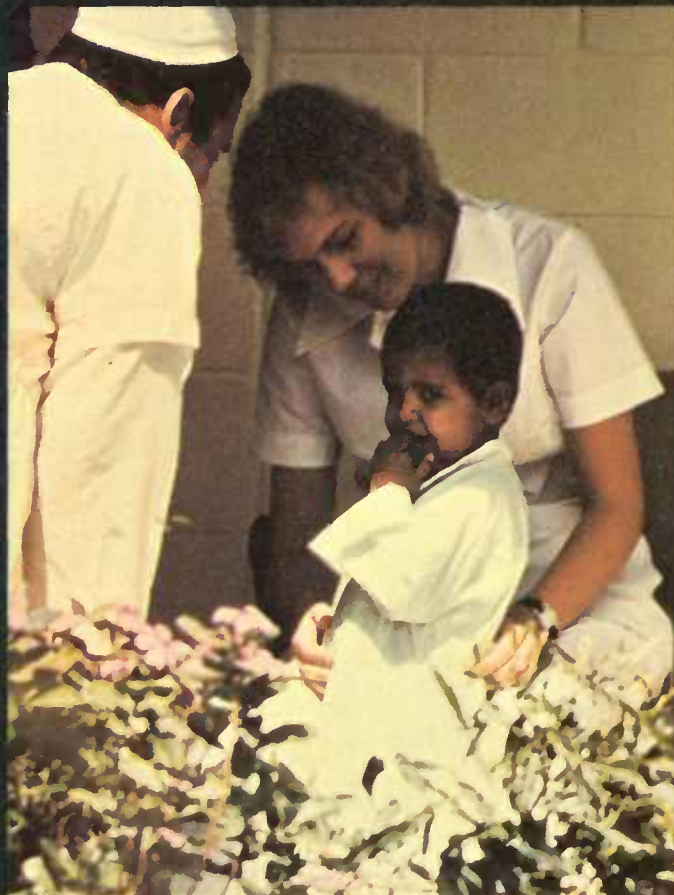




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# The Canadian Nurse

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Separate origins, separate destinies. This month CNJ explores the sensitive area of transcultural nursing, with a feature story by Corinne Hodgson that begins on page 23 and comment on page 5. Our cover photo is courtesy of Health and Welfare Canada.

# The Canadian Nurse

June 1980

Volume 76, Number 6

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The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of The Canadian Nurse. A biographical statement and return address should accompany all manuscripts.

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# perspective

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## Bridging the gap

---

"There are 240 nurses in Canada who are status Indians. Of these, only 20 work in their own communities." Numbers like this, coming from a consultant with the medical services branch of Health and Welfare Canada, make it almost inevitable that right now and for at least the foreseeable future, Canada's native people are going to continue to depend for their health needs on the vagaries of professionals raised and educated under a system that is completely foreign to the recipients of this care.

More than 100 years ago, an Indian chief from the Pacific Northwest commented: "We are two distinct races with separate origins and separate destinies. To us, the resting place of our ancestors is hallowed. You wander far from the graves of your ancestors, seemingly without regret..." Obviously, the opportunities for misunderstanding are both frequent and fundamental.

Nurse Patricia Floyd, middle-aged, single parent of three Indian children, writing in *The Canadian Nurse* special issue on native health care (October, 1978) didn't think the gap was closing. "See the nurse," she wrote. "The nurse is going into the crummy, crowded house. She is going to teach health to the people there...She is going to explain that sleeping four in a bed is a health hazard. She is going to teach about nutrition. She is going to explain that a diet of rice, macaroni, bologna and tea is not good for growing children. Explaining these things is a nursing task. Explaining where they will get the space for more beds or the money for better food is not a nursing task.

"...Now the nurse is going home. She has worked hard. She is a good nurse. She keeps her hands clean. She does not meddle with the tasks of other disciplines. She does not criticize other government departments. She does not get involved in politics.

"She does not have to live on the Indian Reserve."

Cultural blindness, imposition, conflict. The possibility is always there when people of different origins, background and outlook are in day-to-day contact, each dependent on the ability of the other to see beyond and through the superficial and obvious problem to the underlying human need.

"It appears to be a perception problem," Canadian archeologist and northern researcher George Wenzel notes. "Several Inuit people have told me they won't go to the nursing station because 'the nurses dislike Inuit and stay inside all the time'."

Wenzel believes that "without an appreciation of the fact that the Inuit and other native northerners are not southern Canadians, very little can be done to improve the nurse's relationship with the population she serves."

Former Health and Welfare minister David Crombie, speaking six months after his department had announced a new federal Indian health policy, summed up the problem this way: "We must be prepared to break away from models of health care delivery more suited to the urban setting than to the needs of our native people."

If and when this happens and the needs and concerns of Canada's original people are recognized as being neither more nor less, but *different* from general Canadian concerns, it will be nurses who are at the heart of whatever delivery system is set up.

Nurses are an integral and important part of health care in the North just as they are in the South. Transcultural nursing is not confined to certain latitudes or people. Nurses in most of our major Canadian centers in the South also encounter problems of perception and communication every day. How they handle them, the contact they succeed in making with people who are "different", will go a long way to shaping, not only the future health status of people everywhere, but also the wisdom, maturity and "caring quality" of the nursing profession.

M.A.B.



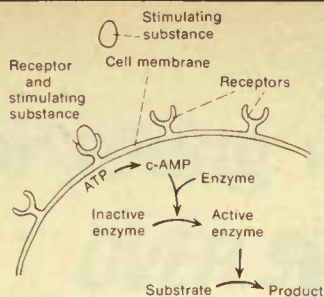


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—Gail Donner, chairperson  
Nursing Department, Ryerson Polytechnical Institute,

## Headed out?

My thanks to Sylvia Segal ("When experience counts") for bringing to light a very important point. All I could feel was very sad. To think that nursing today has to hire volunteers to give support, direction and tender loving care to patients, and the nurse, as ever, sits and writes the notes.

I, for one, am sick of sitting at the desk charting, when all I want to do is be with patients, giving them the support they need. After all that is why I chose nursing as a profession in the first place.

What has happened to the good old days when the head nurse took care of paper work, leaving her nurses to give the necessary care?

Why is it that the paper work has become all important, leaving patients (last in priority) to be cared

for by generous volunteers?

I think nursing should take a good look at its role and where it is heading. I, for one, feel more inclined to want to be one of the volunteers, than the RN I am today.

—Jean Ward, RN, SCM,  
Surrey, B.C.

## Helping skills

I read with concern Sylvia Segal's article (March) regarding the use of volunteers in the obstetrical unit. While I agree that volunteers provide an invaluable service, I am concerned re irresponsible delegation of nursing duties.

The postpartum mother's feeding of her baby is one of the initial tasks in the process of interactional adaptation in the mother-child relationship. Being with the mother at this time, could assist the mother in developmental tasks of mothering as well as enhancing the attachment process.

Essential interventions at this time consist of interpretation of infant behaviors to the mother, positive reinforcement of maternal behaviors and patient teaching. To this nurse-client interaction, the nurse brings her knowledge of communication skills, psychosocial behaviors, physiology, psychology and herself as a therapeutic tool.

It seems inappropriate to delegate such an important intervention to volunteers who operate on good intentions, gut feelings and limited personal experience.

—Donna Roney, Nursing  
Department, Vanier College,  
St-Laurent, Québec.

## A losing battle

"A race against time: caring for a patient with radiation enteritis" (February) was an excellent account of caring for a patient who is fighting a losing battle.

As I read the article I found myself identifying with the nurses and experiencing the frustrations they went through.

Congratulations to Roberta Ronayne for sharing this caring with us. My hat's

off to the team of nurses for the physical as well as psychosocial care given. The author's sensitivity towards both patient and the nurses is very touching.

—Naomi Judah, Halifax, N.S.

## Humanizing the birth experience

It is encouraging to read of the attempts of hospitals to humanize birth such as Ellen Rosen describes in "The Birth Room", (March).

I am distressed, however, that Ms. Rosen and some other health professionals think that the addition of sheer drapes to hide obstetrical equipment and soft colored wallpaper can create a home-like environment. The photograph of the Birth Room with the obvious presence of an incubator and I.V. pole does not look the least bit home-like, even though it is undoubtedly somewhat less frightening to birthing couples than the traditional delivery room.

I was further disappointed that the author did not address the central issue, that of the birthing couple's involvement in decision-making about their birthing experience. She focuses on issues of space, equipment and selection criterion.

I believe that the re-education of staff is an essential issue; without a re-orientation of the role of professionals in supporting birthing couples the cosmetics of the environment are only a token gesture to placate consumer demands.

—J. Alison Rice, RN, MS,  
assistant professor, UBC,  
Vancouver.

## The author replies

In reply to Alison Rice's letter (March) commenting on my article "The Birth Room", you note that I neglected to address the issue of staff education and change, as an essential component of the success of humanization of the birth experience.

I wrote this article in response to many enquiries from nurses in other agencies

who wanted specific information on how to set up such a room. These requests came from nurses who have a high commitment to parent participation in the birth experience, but were having trouble convincing medical staff to make the necessary changes.

I did make reference to the effects of the changes on the staff and the importance of parent participation, but concentrated on describing the physical changes necessary and some of the inherent problems. The subject of staff education and the trial and tribulations of the attitude changes, was left to another paper. This point should have been clearly defined, at the outset.

I appreciate your comments. Thank you.  
—Ellen Rosen, RN, MScN,  
Clinical Nurse Specialist,  
London, Ontario.

## Not abandoned

The February editorial commenting on the Guillain-Barré Syndrome article in the March issue did not reflect the actual cooperative efforts and effectiveness of the medical and nursing staff and the family in assisting in the recovery of the patient with Guillain-Barré Syndrome.

Sometimes, lay people and health professionals who should know better, need to be reminded that, far from abandoning or relinquishing support, families tend to over-extend themselves, often depleting their physical, economic, social and emotional energies. Sometimes this is to the extent that they too may become ill.

—Jill Watt, RN, Ann Calder,  
Vancouver, B.C.

## U of M reunion

Members of the class of 1975 of the University of Manitoba wishing to attend their upcoming five-year reunion should contact:

Sherry Wiebe  
681 Patricia Avenue  
Winnipeg, Man. R3T 3A8

—Patrice Yamada, Winnipeg, Manitoba.



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2 capsules at onset of dysmenorrhea  
followed by 1 capsule every 6 hours for  
the duration of symptoms

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# Ponstan

When it does its job, she can do hers  
every day of the month.

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# UPDATE ON DYSMENORRHEA

## Shortcomings of traditional therapies

Surveys show that up to half of female patients may live a sixth of their reproductive years in pain. Yet many of these women are reluctant or embarrassed to talk about their problem, preferring to self treat with analgesics, or simply accepting their condition.

The Lancet, as recently as 1978, reported: "Current treatment of primary spasmodic dysmenorrhea is unsatisfactory. Powerful analgesics may be habit forming, dilatation of the cervix may cause incompetence, and the use of oral contraceptives seems unjustified unless contraception is required."<sup>2</sup>

## How prostaglandins fit into the clinical picture

In the 1940's it was theorized that a 'menstrual toxin' existed which was involved in causing the pain and other related problems. Recent investigations have indicated that increased premenstrual endometrial prostaglandin levels (particularly levels of prostaglandins E<sub>2</sub> and F<sub>2</sub> alpha) may play an important role in the etiology of dysmenorrhea.

## How Ponstan assists in relieving dysmenorrhea

Most non-steroidal anti-inflammatory agents are inhibitors of prostaglandin synthesis—the enzyme system responsible for the formation of prostaglandin.

The fenamate group of anti-inflammatory drugs have a twofold action: they inhibit the enzymes of the prostaglandin synthesis pathway and also antagonize prostaglandins at the receptor sites.<sup>1</sup>

## Ponstan versus conventional analgesics

Recent clinical trials have demonstrated that Ponstan is, indeed, a useful drug in the treatment of dysmenorrhea, affording relief in some 89.3% of patients cycles.<sup>3</sup>

In a double-blind comparison of dextropropoxyphene/paracetamol capsules (2 caps of 32.5 mg/325 mg t.i.d.) and Ponstan (2 caps of 250 mg t.i.d.), Ponstan was significantly more effective than the analgesic combination on both clinically determined and subjective patient preference assessments. There was also less absenteeism in the group taking Ponstan.<sup>4</sup>

## Alternative therapy to oral contraceptives

Ponstan provides prompt relief of dysmenorrhea, and may thus be considered a more rational therapy than oral contraceptives.

In a recent survey, 55% of women taking oral contraceptives stated that these agents had not solved their dysmenorrhea problems.<sup>5</sup> Ponstan has demonstrated a much higher success rate without disturbing the normal hormone balance of patients. Unlike oral contraceptives, Ponstan is taken only when required, i.e. when menstrual pain becomes evident. For the rest of the month the patient may be free of medication.

## Ponstan: a simple short-term regimen

Patient acceptance of Ponstan is understandably enthusiastic. When pain appears, a patient takes two capsules stat, for fast relief, followed by one capsule every 6 hours for the duration of symptoms.

In addition, Ponstan is well tolerated. Extensive data supports the fact that side effects with short courses of treatment with Ponstan are restricted mostly to minor gastrointestinal disturbances.

### Prescribing Information: PONSTAN CAPSULES 250 mg

**PONSTAN** (mefenamic acid) is an analgesic preparation with antipyretic, anti-inflammatory and antiprostaglandin properties. PONSTAN has been shown to inhibit both the synthesis of prostaglandins and their action on the cell receptor sites.

**INDICATIONS:** For the relief of pain in acute or chronic conditions such as dysmenorrhea, headaches and muscular aches and pains, ordinarily not requiring the use of narcotics.

**DOSAGE:** Administration is by the oral route, preferably with food. The recommended regimen for adults and children over 14 years of age is 500 mg as an initial dose followed by 250 mg every 6 hours as needed. PONSTAN should not be given to children under 14 years of age.

**CONTRAINDICATIONS:** PONSTAN is contraindicated in patients showing evidence of intestinal ulceration. The drug is also contraindicated in patients known to be hypersensitive to mefenamic acid. If diarrhea occurs, the drug should be promptly discontinued. Safe use in pregnancy has not been established.

**PRECAUTIONS:** PONSTAN should be administered with caution to patients with abnormal renal function and inflammatory conditions of the gastrointestinal tract. Caution should be exercised in administering PONSTAN to patients on anticoagulant therapy since it may prolong prothrombin times. PONSTAN should be used with caution in known asthmatics. If rash occurs, the drug should be promptly discontinued.

Mefenamic acid may prolong acetylsalicylic acid induced gastrointestinal bleeding. However, mefenamic acid itself appears to be less liable than

acetylsalicylic acid to cause gastrointestinal bleeding.

**ADVERSE REACTIONS:** In controlled clinical investigation studies of PONSTAN at analgesic doses, up to 1500 mg per day, associated side effects were relatively mild and infrequent. Complaints are dose-related, being more frequent with higher doses.

In 2,594 subjects given mefenamic acid over a period of from 1 to 238 days, the most frequently reported adverse effects were drowsiness (68 subjects), nervousness (28), nausea (20), dizziness (36), gastrointestinal discomfort (10), diarrhea (11), vomiting (5), and headache (2). There were single reports of insomnia, urticaria and dyspnea and facial edema, and 2 instances each of blurred vision, gas and perspiration.

There have been a few reports of hematopoietic side effects. A direct cause and effect relationship has not been established.

**SUPPLY:** Each ivory capsule with aqua blue cap contains 250 mg mefenamic acid. Bottles of 100 and 500 capsules.

FULL PRESCRIBING INFORMATION ON REQUEST

- BIBLIOGRAPHY:** 1. Smith, I.D., Temple, D.M., et al: Prostaglandins 10: 41-57, 1975  
2. Kapadia, L., Elder, M.G., Lancet (1): 348-350, 1978  
3. Pulkkinen, M.O., Kaihola, H.L., Acta Obstet Gynecol Scand 56: 75-76, 1977  
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5. Consensus independent research, 1978. Data on File. Parke-Davis Canada Inc.





### Within psychological confines

I consider the purely psychological approach that Brian Cristall advocates in "Do as I say!" (January) inadequate for the care of the young native girl, daughter of a drunken mother, forsaken by her father, sexually "taken advantage of and beaten by frustrated men."

He states, "There's nothing that you can do to change the economic and social realities" but surely the first thing that should be done for a 14-year-old girl in these circumstances, if unable to change her immediate environment, is to remove her from it. She should have shelter, security, education and preparation for life, as well as help in understanding and resolving psychological problems resulting from her traumatic experience.

I do not believe the present laws of Canada are devoid of protection for a 14-year-old girl in such a situation. If indeed there is no protection in law, then nurses should seek to resolve this at the proper government level.

While nursing is not primarily concerned solely

with psychology or social service, nursing cares for the person as a whole and if that person's well-being requires extending oneself on her behalf, through failure of social service and psychiatry and psychology, I am quite sure nursing would not tolerate such a situation without seeking to better it. —Margaret McLaughlin, RN, Toronto, Ontario.

### The Case of "Eve"

Corinne Sklar's *You and the Law* (March) has motivated me to write. As a nurse (non-practising), wife, mother and sterilized person (tubal-ligation), I get so upset when I read of cases such as "Eve's". In my opinion, the courts should not be deciding on medical matters.

I wonder whether the people involved have any understanding of human sexuality. Do they think that tubal-ligation robs females of their sexuality? Do they think that the essence of being female is limited to the baby-making ability? I look forward to the possibility that *The Canadian Nurse* might have future articles on this subject.

—Name withheld on request.

### Low status — not us!

The opinions expressed by F.M. Tufts in the February issue of *The Canadian Nurse* have alarmed us: we do not consider obstetrical nurses "low on the totem pole" but rather equal members of the health care team. Nurses who are not challenged by maternal-newborn care should move on to another facet of nursing of their choosing.

Interest in OB nursing can be generated in the basic nursing curriculum and by attaining government recognition. In the province of Nova Scotia maternity nursing has been promoted by programs such as the Nova Scotia Reproductive Care Program and the Maternity and Neonatal Courses offered by the Grace Maternity Hospital.

The OB departments of our hospitals therefore continue to be staffed by hospital administrators and directors of nursing with an equal interest and insight.

Nurses owe it to themselves to educate themselves, to develop orientation and ongoing educational programs that result in highly skilled and competent maternity nurses. —M. Johnson, R. Steele, M. Power, Grace Maternity Hospital, Halifax, Nova Scotia, and S. St. Lewis, Post RN Program, Dalhousie University, School of Nursing

### Partners in caring

I am a family physician in a community health clinic and I am disturbed to see young interns and older doctors treating nurses like inferior beings. Why is this still happening in a day and age when we are striving towards the "health care team" approach?

Is the ego the predominant force in physicians or are they covering a lack of confidence? Do they not realize that nurses are taught substantially more than how to take blood pressure and pulse? Have they been taught in medical school that nurses are stupid and unable to participate in rational decisions about patient care?

As members of a health care team we all have something to contribute and something to learn from each other. Nurses are the first line of contact for patients in hospital, making their role

vital. In an office setting, teamwork between physician and nurse provides more efficient, thorough health care.

I hope nurses will be accepted as colleagues by the new generation of physicians; this is the only way the health care system will run efficiently.

—Richard W. Swanson, B.Sc., MD, LMCC, MCFP, Saskatoon Community Clinic, Community Health Services (Saskatoon) Association Ltd.

### A "comforting role"

I found "Herpes: scourge of the seventies", (January) very interesting and well-written but was disappointed to note that the role of the nurse was described as one of comforting and reassuring patients.

I feel that everyone — including interns and residents — should consider that their duty. Nurses also have another important role to play in connection with sexually transmitted diseases — that of prevention, screening and education. G.J. Croteau, BScN, PHN, Montréal, Québec.

### Is your image slipping?

I wish to condemn the sexist and condescending caricature of nurses presented on the television program "Trapper John M.D.". As a professional who has both studied and worked hard, I deeply resent this portrayal of the nurse offered for public consumption.

At a time when nurses are attempting to redefine their role in the public eye, such programs are incredibly influential. Will we sit quietly and take this? I have written a personal note of protest to the series. I'd love my association to do the same! —S. Perry, RN, Edmonton, Alberta.

### Royal Jubilee

The Royal Jubilee Hospital School of Nursing, Victoria, B.C., is one of the oldest schools of nursing in Canada. The Alumnae Association is planning a reunion to celebrate its 90th year to be held on June 4, 5 and 6th 1981. Former graduates interested in further information should write to:

Mrs. R. Anderson  
Apt. 104-2333 Beach Drive  
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A well established 15 week Adult Intensive Care Certificate Nursing Course offered annually in the Fall and Winter. This program offers a rigorous and well-balanced course of studies in the concepts, skills and knowledge required to work in the rapidly developing areas of Intensive Care. Graduates of this program may be eligible for credit towards the degree. Both programs emphasize nursing assessment skills, pathology and an integrated clinical experience.

For further information, contact:

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## Maria Zinck wins 3M scholarship

For the second time in ten years, a Canadian nurse has been awarded a \$6,000 3M (Minnesota Mining and Manufacturing Co.) International Council of Nursing Fellowship for nursing studies. Maria Dina Zinck, of Antigonish, Nova Scotia, hopes to complete a doctorate in nursing at the University of Toronto. Her primary interest lies in nursing education.

In 1973, Alice J. Baumgart of Vancouver, B.C., won the award. Baumgart studied health service problems and planning of health services at the University of Toronto and has since gone on to become Dean of the School of Nursing at Queen's University in Kingston, Ont.

Zinck was chosen from among 52 candidates by a committee of the International Council of Nurses in Geneva, Switzerland. Other nominees came from countries such as France, Ghana, Poland and Sri Lanka.

An assistant professor at St. Francis Xavier

University in Nova Scotia, Zinck holds a master's degree in adult education and a bachelor's degree in nursing science. During the past 13 years of her nursing career, she has held a wide range of supervisory positions. As a member of Canadian University Students Overseas (CUSO) she was in charge of a rural hospital in Peru and for two years was the organization's Atlantic region executive secretary.

Since 1966, Zinck has recruited professional and technical volunteers for overseas assignments and has trained students from more than 60 countries in social leadership. She has prompted awareness of international development through her numerous lectures on international health problems.

A second fellowship of equal value was awarded to a Jamaican nurse, Valerie J. Hardware. Hardware will use her scholarship to obtain a bachelor's degree at the Faculty of Medicine at the University of the West Indies in Kingston, Jamaica.



3M scholarship winner Maria Zinck of Antigonish, N.S., receives the award, along with a trophy symbolizing the flame of life, from 3M representative Gene Lewan. Also on hand for the ceremony were RNANS executive director Joan Mills, (far left), 3M sales manager Ted Williams and Phyllis Manchester from the Higher Education Group, Ontario Institute for Studies in Higher Education.



Four nurses – Sharon Ramstad of Camrose, Alta.; Mary Myles of Fredericton, N.B.; Barbara Rodney of Yarmouth, N.S.; and Barbara Ann McWilliams of Vancouver – were among 21 Canadians who received lifestyle awards at a ceremony in Ottawa this Spring. The awards, for outstanding contributions to the development of positive lifestyles in their communities, were first presented in 1977 as part of Health and Welfare Canada's philosophy of encouraging Canadians to assume greater responsibility for their own health and well being.

## Six nurse coordinators help international study

Does controlling high blood pressure with treatment that includes a beta-blocker (slow oxprenolol) significantly change the incidence of heart attack and sudden death? This is the question being investigated through a major research project sponsored by Ciba-Geigy Pharmaceutical Company. Currently, six countries are involved in the trial: Germany, Holland, Great Britain, Israel, Italy and Canada. Six centers in Canada will be contributing a total of 700 patients and by 1981 world-wide enrolment will stand at 5,000.

Dr. Alexander Logan of Toronto is Canadian Principal Investigator, for this five year International Prospective Primary Prevention Study in Hypertension (IPPPSH). Day-to-day conduct of the trial is carried out in each of the six centers and coordinated by the Medical Department of Ciba-Geigy Canada in Dorval, Quebec. Each center has a medical investigator and a nurse-coordinator working on the project:

Dr. Alexander Logan and Barbara Milne, Mt. Sinai

Hospital, Toronto; Dr. Victoria Bernstein and Norma Kent, Vancouver; Dr. Yves Lacourciere and Jocelyn Garneau, Centre Hospitalier de l'Université Laval, Québec; Dr. Carl Abbot and Karen Mann, Camp Hill Hospital, Halifax, N.S.; Dr. Peter Fernandez and Dr. George Fodor, Shirley Granter and Jackie McDonald, two centers in Newfoundland connecting with the St. John's General Hospital. In addition there is a national electrocardiogram center directed by Dr. P. Rautaharju at Dalhousie University in Halifax, N.S.

The responsibilities of the nurse-coordinators for this project include a variety of functions: facilitation of patients through the entry procedures, long term monitoring of blood pressure, patient counseling and documentation of data.

The control group for this study will be patients being treated for hypertension according to standard medical practice, but not receiving a beta-blocker drug.



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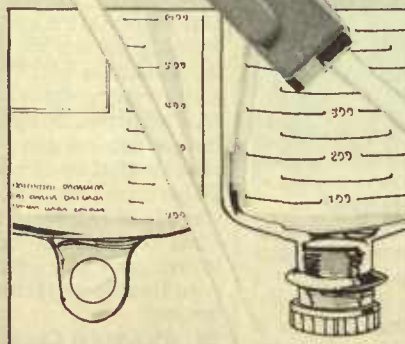
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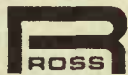
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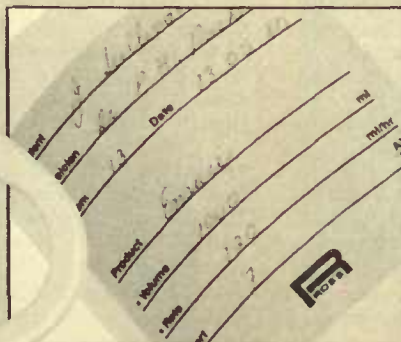
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# NEWS FEATURE

## Locating Nursing Research Data Via Computer

A.C. Lynn Zelmer

Since 1977 nurse researchers across Canada have been able to "telephone" the University of Alberta to obtain the information they need on research already in progress. Using a suitable computer terminal and a telephone coupler (modem), they can call for and receive information on current thesis and non-thesis research at Canadian nursing institutions.

The Faculty of Nursing at U of A implemented CORN (Canadian On-going Research in Nursing) in 1977; using information supplied by about ten cooperating institutions the faculty agreed to maintain a computerized data base on a trial basis. *Datapac*, the computer access system which uses special long distance telephone lines, provided access for users outside of Edmonton and the Faculty of Library Science prepared a search-retrieval program to work with the university's Amdahl computer.

The data file contains the proposed title of the thesis or report; names of researchers, supervisors and sponsoring institutions; date of initiation of the project; and keywords describing the project. Information may be entered and searched in either French or

English. A thesaurus prepared by the Canadian Nurses Association allows those entering information to list keywords in both languages. The file allows researchers to identify persons working in similar fields and should help prevent duplication of effort in a field with limited financial and research resources.

The data file has not eliminated the need for conventional publication of research results, but it has decreased the time required to disseminate information about research projects. Users of the CORN system can write directly to the individual researcher for information while research is in progress. Information on the file is updated quarterly, with the cooperating institutions and individuals sending additions/deletions and corrections through the regular postal system.



The program is not without its faults: data accuracy is dependent upon the researchers themselves, and how they describe their research. Since many of the researchers are not bilingual they fail to include keywords in both languages. The standard lexicon also seems to be inadequate for describing research occurring in some of the newer areas of nursing interest. This results in the use of terms which cannot be easily translated. Both data input and search processes suffer from the hazards of

computer "logic" which dictates an absolute protocol of blank spaces 'primes' and format. Forget even a single blank space and the computer aborts the search with the frustrating message "Error, you probably forgot..."

Nevertheless, use of the CORN system is increasing and Dr. Amy Zelmer, Dean of Nursing and initiator of the service, indicates that the problems are being overcome. "CORN has given us considerable information about the needs of practitioners who use data files. The current program is oriented towards users who understand computers. Hopefully we can make the necessary changes that will allow better access by individuals who don't want to understand computers."

CORN is accessible by anyone who has the use of a suitable terminal. Once the user is signed on to the computer system, CORN prompts the user (in both French and English) for the search parameters. Signon information and a user's manual with more complete instructions are available from the U of A Faculty of Nursing.

### Health and Welfare issues warning

The Health Protection Branch of Health and Welfare Canada has informed CNA that they have received a number of reports of perianal excoriation associated with laxatives containing dioctyl sodium sulfosuccinate. The problem apparently occurs when incontinent patients are given this detergent stool softener and the fecal matter makes contact with their skin for prolonged periods of time. Marked scalding of the buttocks and groin are often seen within two to three days of initiation of the medication and a few patients have had abdominal discomfort. There have been few or no problems in patients who are not incontinent.

Ian Henderson, Director of the Bureau of Drugs, states, "It seems reasonable to recommend that detergent products be deemed not appropriate for use in geriatric non-ambulatory bed-ridden patients who are at all incontinent, when it cannot

be assured that the perianal skin will stay dry and feces-free."

### Planners ready for continuing ed meeting

Organizers of Canada's first national continuing education in nursing conference which is scheduled to take place in Vancouver June 26 and 27, have announced the name of the major resource person for the meeting. She is Dorothy del Bueno, associate dean of continuing education at the University of Pennsylvania and consultant in in-service education at the Hospital of the University of Pennsylvania.

The conference theme is "Continuing nursing education: planning for the '80's". The conference is intended to assist individuals responsible for continuing nursing education by providing them with information about strategies for cost effective educational programs. It is intended for nurses working in health care agencies, educational institutions, professional associations and government organizations. Registration is limited to 150 persons.

### Nurse administrators conference

The administration of nursing in the 80's will be the theme for the First National Nurse Administrators Educational Conference to be held in Vancouver, B.C. on June 25 and 26.

The plenary session will focus on topics such as management information systems, maximizing the use of staff, the impact of new technology, coordinating care internally and externally and organizational models. Small group sessions will follow where participants will deal with one of the above topics in greater depth. The challenges and stresses faced by administrators will be dealt with in two separate plenary sessions.

The conference is sponsored by the Canadian College of Health Service Executive in cooperation with the Canadian Nurses Association and the Nursing Administrators Association of British Columbia. The \$95 fee includes lunch and materials.

### Did you know...

A new chapter of the Canadian Orthopaedic Nurses Association has been formed in Nova Scotia with approximately 70 members. Monthly educational meetings are held in the Halifax area. If you are interested please contact: Carolyn Gesner, RN, Chairman, Membership Committee, Nova Scotia Chapter, C.O.N.A., V6 West, Victoria General Hospital, Halifax, N.S.

### Health happenings

Fifty nurses working in Canada's north have united to set up their own professional association which will stage its first annual general meeting in May of this year. The Yukon Nurses Society was officially incorporated and registered early in 1980. The fledgling association has as its main objective the provision of educational programs and information for its membership. ❖



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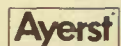
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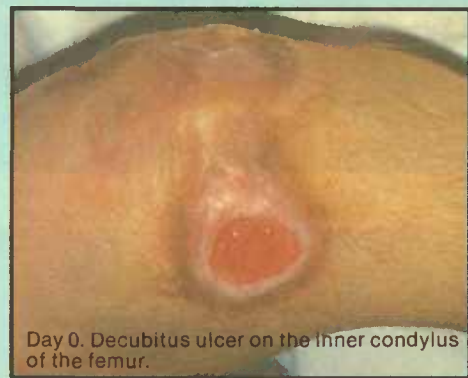


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# medicine for decubitus ulcers.



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**Day 7.** Conventional dressing changed twice.



**Day 1.** Exudate accumulating under Op-Site.



**Day 7.** Ulcer almost closed.

ous exudate, and this is the key to faster healing.<sup>1</sup> The exudate provides the ideal environment for tissue regrowth, and is rich in leukocytes which are instrumental in controlling pathogenic bacteria.

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1. Winter, G.D.: Healing of Skin Wounds and the Influence of Dressings on the Repair Process—Surgical Dressings and Wound Healing, Harkiss, K.J. (Ed.), Bradford University Press, 1971.

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# YOU AND THE LAW

Canada's highest judicial authority, the Supreme Court, will rule this year on two cases, *Reibl v. Hughes* and *Lepp v. Hopp*, dealing with the issue of what constitutes informed consent to medical treatment, a question which has given rise to more and more litigation recently. Some of the confusion which now surrounds the issue appears to have been influenced by the U.S. situation where a dichotomy in judicial approach has created controversy in the last few years. In Canada this has exposed a noticeable lack of clarity and consistency in trial and appellate decisions at the provincial level so that, until the results of these two current appeals are announced, health professionals remain up in the air about the standards that apply in this country.

Corinne Sklar



## Was the patient informed?

The patient's consent to treatment is required before those delivering health care can lawfully minister to the patient: failure to obtain this consent abrogates the patient's basic legal right to determine what shall be done with his own body.<sup>1</sup> This right of self-determination and control over invasion of the individual's person is a basic legal right which the law scrupulously upholds: to touch another without his consent, either express or implied, constitutes the civil wrong of battery. The individual's consent to the touching validates the conduct. For those delivering health care, there is another "answer" to a complaint of touching without consent, i.e. the emergency, in which a threat of danger to life, health, limb or vital organ provides lawful justification for such touching. Our courts have upheld such medical intervention when necessary to safeguard the patient's life or health,<sup>2</sup> but not where the treatment has been completed merely because it was, at the time, medically convenient.<sup>3</sup>

For consent to medical treatment to be valid in law, four requisite elements must be present:

- capacity of the patient
- voluntarily given
- corresponding to the act performed
- informed to the degree required by law.

It is the "informed" aspect that requires clarification by the Supreme Court: for the patient's consent to be valid, he must understand the nature and purpose of the contemplated treatment, the risks of agreeing to it and the risks of refusal to be so treated. In other words, the patient must have all the facts necessary in order to make a reasoned decision as to whether or not he will undergo the proposed treatment and in order to do this, he must be given sufficient information in language he can understand.

How much information must the physician disclose? Case law says that physicians must disclose all material facts to the patient but physicians must also protect their patients from undue alarm. What degree of disclosure will suffice?

The position taken by Canadian courts has been to require that the explanation be honest, reasonable and fair so that the patient has enough information to understand fully the nature of the treatment and the reasons it is necessary. Prior to *Reibl* and *Hughes*, a Canadian physician had to disclose risks that were material and those his professional colleagues would normally have disclosed. In addition the physician had to subjectively assess the patient and make the explanation having regard to the intellectual and emotional characteristics of the patient. He also had to consider the degree of dependency this patient had in the physician-patient relationship.

*"...the paramount consideration is the welfare of the patient, and given good faith on the part of the doctor, I think the exercise of his discretion in the area of advice must depend upon the patient's overall needs. To be taken into account should be the gravity of the condition to be treated, the importance of the benefits expected to flow from the treatment or procedure, the need to encourage him to accept it, the relative significance of the inherent risks, the intellectual and emotional capacity of the patient to accept the information without such distortion as to prevent any rational decision at all, and the extent to which the patient may seem to have placed himself in his doctor's hands with the invitation that the latter accept on his behalf the responsibility for intricate or technical decisions..."*<sup>4</sup>

Physicians do not have to disclose all of the risks which are usually inseparable from any surgery such as the dangers from undergoing anesthetic, the risk of infection, etc. These are considered to be generally known.

Some areas of the United States however have adopted the "full disclosure" standard which demands that the physician disclose to the patient all significant risks, whether material or remote. The test is an objective one, that of the informational needs of the reasonable and prudent person in the patient's condition, armed with complete

knowledge of all of the facts, who makes a reasoned decision as to whether to accept or reject the proposed treatment. This approach does not consider the needs and characteristics of the actual patient.

Cases where the informed aspect of the consent obtained has been questioned raise the following points:

1. If the consent is not informed, was the doctor only negligent or was there no consent at all so that the wrong of battery has also been committed? (There are important legal differences in the proof and presentation of the case, depending on whether battery and/or negligence is alleged.)
2. What degree of disclosure constitutes an informed consent?
3. By what test is the patient to be measured? Is it a subjective evaluation of the intellectual and emotional qualities of that particular patient or is it an objective test of the reasonable prudent patient in similar circumstances? (This is important because the question to be answered here is would the patient [subjective or objective standard applied] given the facts have undergone the treatment?)

The stage for the current appeals to the Supreme Court of Canada was set in 1976 by the Ontario case of *Kelly v. Hazlett*<sup>5</sup>. Before that, cases alleging an absence of informed consent were usually framed either in negligence or battery, mostly the latter. In *Kelly v. Hazlett*, Judge Morden (as he then was) considered the American situation and in his decision differentiated between the battery and negligence action. If the physician failed to inform the patient of risks material to or basic to the treatment, then there was no consent and battery had occurred. If, however, the undisclosed risks were not basic to but only collateral to the treatment, then the physician had failed to live up to the professional medical standard and his conduct amounted to negligence.<sup>6</sup> This decision was not appealed but was followed in *Reibl v. Hughes*<sup>6</sup> and referred to in *Lepp v. Hopp*, the two cases now on appeal to our Supreme Court.



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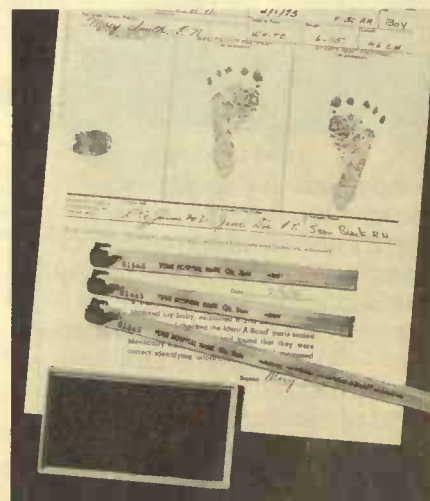
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### Case one: Reibl v. Hughes

In *Reibl v. Hughes*, the plaintiff was a 50-year-old married father of four who, at the time of the onset of his symptoms, was working on the Ford assembly line in Oakville. In 1968-69, he developed severe headaches. His physician diagnosed hypertension and prescribed medication. When the patient failed to respond, he was admitted to hospital for testing, the results of which were inconclusive at that time except for a finding of mild diabetes to be controlled by medication and diet.

The headaches continued. Investigation by the defendant neurosurgeon revealed a left carotid artery murmur indicating narrowing of the vessel. Arteriography indicated stenosis of 80 to 90 per cent. Although the defendant determined that this

finding was not the cause of the headaches, he was of the view that the affected area should be removed to reduce the risk to the patient of a stroke. The defendant performed an endarterectomy in March 1970 but, either during or after the surgery, the plaintiff suffered a massive stroke which paralysed the right side of his body. He will never work again.

The trial judge found that the neurosurgeon "did not take sufficient care to convey to the plaintiff and assure that the plaintiff understood the gravity, nature and extent of risks specifically attendant on the endarterectomy, in particular the risk that as a result of the operation he could die or suffer a stroke of varying degrees of severity".<sup>7</sup> The trial judge found that the defendant knew that the

cumulative risks of death or neurological damage were about 14 per cent yet he did not inform the patient of this. The judge called this degree of disclosure negligent and described the duty of a surgeon as "relating to the specific risks within the surgeon's knowledge peculiar to the contemplated treatment".<sup>8</sup> He stated that, in his opinion, if the patient had been fully informed of the risks, he would not have consented to the surgery. The trial judge held that "the consent" obtained, being not properly informed, was not legally valid and therefore the civil wrong of battery had been committed.

On appeal, the Ontario Court of Appeal ordered a new trial. The appellate court found that the trial judge should not have injected the issue of battery (no valid consent because not informed) in a case where negligence (failure to meet the required standard of care in disclosure) alone was alleged. In its view, the physician did not have to give the patient statistical risks of paralysis or death. The patient seemed aware of the risks from the questions he raised when the surgery was discussed. The trial judge had imposed a test of disclosure greater than the test of disclosure required by law.

With respect to which test should be applied to the patient, given the effect of hindsight on any such determination, the Court referred to the usual application of the subjective test in Canadian jurisprudence. The Court's opinion was that safe practice would be to test the patient's decision objectively (ie. based on the reasonable prudent patient) and only then consider it subjectively (ie. based on the characteristics of the actual patient).

### Case two: Lepp v. Hopp

In *Lepp v. Hopp*,<sup>9</sup> the issue of informed consent again was before the Court. In this case, the question of the degree of disclosure required in response to a patient's questions was also considered. Here the patient was a retired farmer, 66 years of age, who developed severe pain in his left upper thigh, hip and groin areas. The patient was diagnosed as having a "slipped disc", with the prolapse of disc material protruding in the area of the third and fourth lumbar vertebrae exerting pressure on the spinal cord in that area.

After the patient had been hospitalized, his family physician called in the defendant, an orthopedic surgeon. A myelogram confirmed the diagnosis made by both physicians. After discussion with the patient, and the patient's consent to surgery having been obtained, the defendant performed a hemilaminectomy. However, the patient did not continue to improve as expected and a subsequent X-ray one month later based on a residual amount of contrast medium disclosed a complete block at the same stage. This was in contrast with the results of an X-ray taken five days postoperatively which showed that some of the contrast medium had passed through the former area of blockage.

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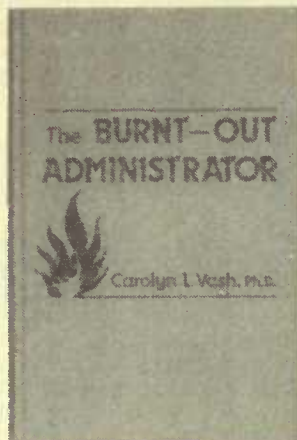


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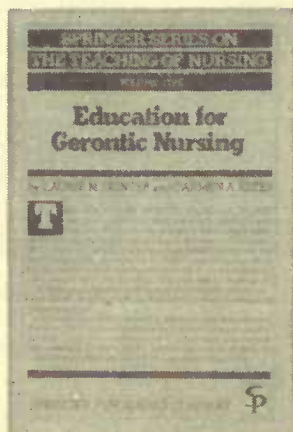


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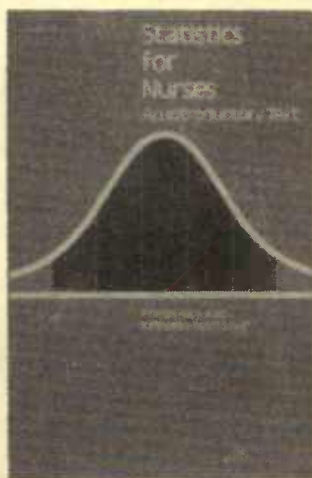
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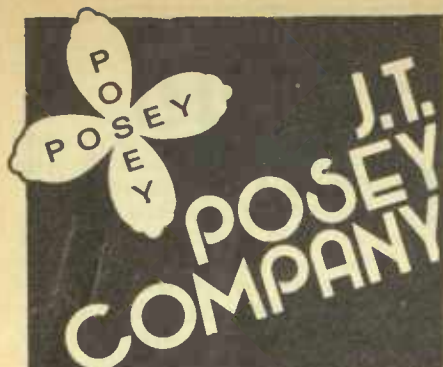
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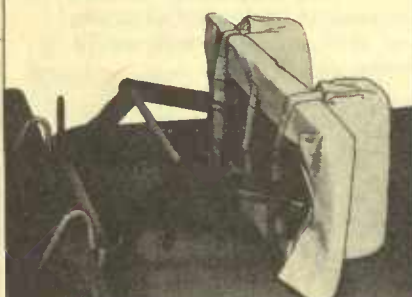
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The defendant referred the patient to a neurologist in Calgary, 100 miles from the site of the first surgery in Lethbridge. A further myelogram confirmed the complete blockage in the area of the third and fourth lumbar vertebrae. On referral to a Calgary neurosurgeon, an extensive decompressive laminectomy was performed. During this surgery a large portion of extruded disc material was removed from the space between L3 and L4.

The plaintiff now suffers severe weakness and loss of sensation in his legs and is unable to walk without a cane. He has severe disturbance of bowel and bladder function. The trial judge found these injuries to be permanent and that their cause was due to the pressure damage to the nerves which resulted from the extruded disc material.

The trial judge found no negligence on the part of the defendant orthopedic surgeon who performed the first surgery. In his view, it was purely speculative to determine whether the additional disc material had become extruded at the time of the first surgery or thereafter. He found that the defendant had found the spinal cord to be freely moveable after his removal of the offending disc material.

The trial judge also found that the defendant had not failed in obtaining an informed consent to the procedure. At issue was the question whether the surgeon had to disclose to the patient that this was the first time he would be performing this type of surgery alone; the defendant had performed this type of surgery many times under supervision while completing his residency in orthopedic surgery. After a review of his qualifications and experience, it was held that there was no obligation to inform the patient that this was the first time he had performed this type of surgery since obtaining his certification. This issue was not raised on appeal.

The plaintiff had asked the defendant, however, how serious the operation was and whether it should be done in Calgary, rather than in Lethbridge. The response had been that the operation was not serious and that he, the defendant could do it as well as any doctor in Calgary. Did this response fulfill the requirements of an informed consent?

The trial judge found that this was sufficient and dismissed the plaintiff's claim; he was satisfied that the Lethbridge facility was suitably equipped to handle such surgery and that no unreasonable risks were involved.

This decision was overturned on appeal. The Alberta Appeal Court majority decision awarded the plaintiff damages of \$15,000. The Court here held that specific questions directed to the surgeon require a full and fair disclosure in response. Once asked, it was incumbent upon the defendant to discuss with the patient the possible

risks and the convenience and expertise involved in each alternative; to do less was inadequate and, in the circumstances, misleading. The Court found the defendant liable in both battery (no valid consent because not informed) and negligence (failure to meet the required standard of care in disclosure).

The Appeal Court majority accepted the traditional tests of the medical professional standard for the doctor and the subjective standard of assessing the patient. The dissenting opinion<sup>10</sup> in the Alberta Court of Appeal held that the patient's general query regarding the seriousness of the surgery did not constitute a specific question requiring the more full and frank disclosure. In this view the defendant was not negligent or in breach of any duty to the patient in the disclosure so made.

The direction Canadian law will take regarding the approach and degree of disclosure required of physicians will be determined by our Supreme Court. It is to be hoped that the Court's decisions in these cases will clarify the law with respect to informed consent so that physicians, lawyers, patients and all those delivering health care will have a clear appreciation of what the law requires. ♡

*"You and the law" is a regular column that appears each month in The Canadian Nurse and L'infirmière canadienne. Author Corinne L. Sklar is a recent graduate of the University of Toronto Faculty of Law. Prior to entering law school, she obtained her BScN and MS degrees in nursing from the University of Toronto and University of Michigan.*

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- 10 \*Note that there was also a dissenting opinion in the Court of Appeal in *Reibl v. Hughes* but this dissent was not directed at the issue of liability but rather at damages which Haines J. at trial assessed at \$225,000.

\* Unable to verify in CNA Library



We know that attitude plays a large part in how successful treatment will be. Separating culture from illness is like trying to separate mind from body: the relationship between the two is so complex that division is almost impossible.



Photo courtesy of Health and Welfare Canada

# TRANSCULTURAL NURSING

Corinne Hodgson

In interethnic relations in city hospitals, in outpost nursing and in many other areas of practice, nurses are often called upon to give care to people of another culture. The field of study concerned with this area of nursing has become known as "Transcultural Nursing". Madeleine Leininger, one of the first nurses to study and write extensively about this subject, considers cultural factors an integral part of providing total health care services to people: "Nursing and health services cannot be adequate, effective or comprehensive unless cultural aspects of health and illness are given full consideration."<sup>1</sup> Last Summer I spent time in the Canadian North talking to nurses practicing there. What has Leininger's subdiscipline to offer outpost nurses? Is transcultural nursing different from nursing people of your own culture?

## The Canadian Experience

In 1975, an Inuit Councillor speaking at a northern health conference made this statement:

"I don't know exactly how many beds there are in the Nursing Station — some have been added on — but for whatever reason it seems that the nurses don't want to use the beds. Maybe they don't want to get the beds dirty. Maybe they consider Inuit too dirty to be in those beds."<sup>2</sup>

What happens when patient and practitioner see things in fundamentally different ways? Hazel Weidman suggests:

"One distressing outcome of unicultural or unidirectional encounters may be that the patient's concerns focus upon an entirely different kind of problem from that upon which the health professional's attention is centered. The latter could be responding to the same set of symptoms as the patient, but his efforts might be directed toward treating the patient in ways that have no meaning for him. Such instances begin to border on an unintended but very real intolerance and contempt for the patient's cognitive system."<sup>3</sup>

Are the concepts of transcultural nursing applied in the Canadian North? Occasionally, but mostly on individual initiative. Neither the standard nursing curriculum nor the orientation provided by National Health and Welfare really explains native Canadian culture to new nurses. They pick up their knowledge largely through trial and error, a slow and costly way of learning. All goodwill aside, under such conditions misunderstandings are inevitable for both sides.



To understand what they might want from health care, we must consider the history of native Canadians. Before the arrival of the Europeans, all native groups were self-sufficient in this area. In their world "health" was never an isolated element of behavior, but an integral part of cultural and social life. Illness that would not respond to home (usually herbal) remedies were often interpreted as the result of social or religious violations by the patient or a member of his family. The healer was called upon to restore the balance of man, society and the supernatural; he thus combined the roles of medical practitioner, judge, policeman and priest. A healing ceremony involved not only the patient and healer, but also the family and community of the sick person. The medical rite thus contained social, psychological, cultural and religious elements.

Later, health care was provided mostly by European missionaries. Certain similarities existed between the traditional "shaman" or healer and the doctoring missionary. Both men combined curing with religious duties and both were concerned with the structure and functioning of the society as a whole; the shaman to maintain social harmony and his own position, the missionary to civilize, Christianize and westernize. It is not surprising that many Inuit remember the medical care given by the missionaries with fond nostalgia, even though the quantity and quality of this care was very different from today. The nursing missionary or nun cared about your soul as well as your broken arm, and generally lived in close contact with the native people. It is interesting to note that the modern Inuit word for nurse is "nayanguak" which translates as "fake nun".

What prompted the Inuit Councillor's remarks about the nursing station beds? Having talked to many of the nurses in this area, I feel confident in saying that the nurses aren't afraid to use their inpatient facilities and don't consider the Inuit "too dirty to be in those beds". Rather, the nurses feel that part of their job is to teach basic home care and probably assume that patients who don't require constant nursing supervision would be happier at home. To these nurses, the station is not a hospital, but a clinic, and people are kept as inpatients only if it is an emergency. The Inuit, on the other hand, tend to confuse nursing stations and hospitals and to expect inpatient care as given by the doctoring missionaries. Not knowing that the Inuit are used to total care from a healer, the nurses probably assume that the Inuit

will understand why they are sending the patient home and explain it only briefly. The Inuit, expecting something different, probably suspect that the nurses' explanation, if one is given, is an excuse for her to duck out on her responsibilities. Each side is acting in a manner consistent with its culturally-derived ideas of what constitutes health care, without realizing that the other side sees things very differently.

A similar problem is encountered when northern nurses attempt to establish regular clinic hours for remote stations. Traditional Indian and Inuit cultures possess the concept of time, but not the precise, measured units used by western society. Furthermore, the early nursing missionaries probably saw their work, including any after-hour calls, as part of their Christian duty. Modern day nurses, however, would like to establish regular clinic hours so they too can have some time to themselves. Such a concept may be difficult to introduce, and the nurses are constantly teaching the community the clinic hours, what constitutes an emergency, and symptoms that can be safely treated at home until the clinic opens. Unfortunately, conflict is still generated by this issue. Unnecessary after-hour calls or a rush of stragglers just before closing time can be very annoying for the nurse and can cut seriously into her free time. In remote settlements it is often very difficult for an outpost nurse to emotionally and physically leave her work behind her, especially if she is living at the station. Many native people do not understand why the nurses find these interruptions so annoying. "After all, why shouldn't a nurse want to nurse at any time? Isn't that her job and her life? What's so special about seven p.m. as opposed to five p.m.? If hospitals provide around the clock care, shouldn't that big station with three nurses do the same?"

Problems like this, which seem small on the surface, can aggravate basic differences already existing between native and white people in remote settlements. The outpost nurse not only works in these communities, but lives there as well. In order to become part of that community, she should make friends with both her white and native neighbors. Making friends involves not only commitment, but an investment of time and emotions. Often neither the nurse nor the community member is willing or able to make this commitment. Most native people in the north have experienced a long succession of temporary nurses with whom they have little, if anything, in common. Although some nurses do establish viable friendships with native people, many nurses find it difficult to overcome the linguistic, cultural and educational barriers between themselves and the majority of their native patients. It must also be remembered that a nurse may find it equally difficult to find someone of similar tastes and interests among the small white contingent of a remote community. Although no one is at "fault", a northern nurse may find herself socially isolated, so that interactions with the community are limited to a "single strand" or professional format. Needless to say, this is not healthy for either the nurse or the community. When native people complain that nurses don't "like" them, they are probably commenting on the separation of medical care from culture created by modern medicine. This separation is greater when such care is applied to northern communities. Native people may find medical services psychologically unsatisfying and socially alienating unless they can establish ties with the healer and vice versa. The medical practitioner must not only cure the disease but heal the patient as well. Healing has been defined as "restoring the sick to the world of the healthy".<sup>4</sup> It is a continuation of the curing process rooted in a positive and personalistic practitioner/patient relationship.



Photo courtesy of Health and Welfare Canada



To establish such a relationship, white nurses and native patients must achieve cross-cultural communication. This can be extremely difficult for new nurses. Often the very young and very old in the north, specifically those most in need of reassurance when ill or injured, do not speak English. Even when a patient speaks English or an interpreter is available, he/she may be intimidated by the station and/or unwilling to answer personal questions. Furthermore, the body language and communication patterns common to many traditional Indian and Inuit groups are different from those used by Euro-Canadians. Eye contact, for example, is avoided by many Indian groups as a sign of respect or when one is uncertain about a relationship or a situation. Lack of eye contact and very subtle facial expressions can make it difficult for some Euro-Canadian nurses to "read" native patients. Reading a patient is essential, however, if a nurse is to reassure someone who is frightened or lonely. As an Indian councillor recently pointed out:

"Most often the hospital is a foreign, cold and unwelcome place for our people...That doesn't mean that the hospital staff are cold or prejudiced by intent. Those are just the feelings our people get."<sup>5</sup> Again, lack of cultural understanding is probably the real villain.

In situations where communication between different cultures is necessary, "transcultural nursing" studies could be a valuable aid: understanding why people are behaving in a manner different from our own, we have a logical basis upon which to interpret that behavior and plan our response. Leininger argues that "caring is the basis to curing effectiveness"<sup>6</sup>, and whether in the north or the south, nurses are the source of this care. If nurses cannot develop lines of communication with their patients, this care is patchy and prone to misunderstandings and breakdown.

Concepts of transcultural nursing are as important in urban hospitals as in the remote north. Any time a nurse cares for a patient from another cultural or ethnic group, problems in communication can occur. As pointed out by many authors, body language alone varies widely throughout the world. The cultural backgrounds of the nurse and the patient can determine both how the patient will react to his illness (as well as how his family will act), and how the nurse will interpret this behavior.

## CHECKING OUT YOUR OWN "CULTURAL AWARENESS"

Gail O'Neill

Are you conscious of the dominant values of your own culture? Pervading North American society and creating a strong influence on behavior, we have such cultural values as:

- optimal health
- democracy
- individualism
- achieving and doing
- cleanliness
- time
- automation

A distinction should be made between two major categories of cultural behavior: *manifest culture* refers to patterns of actions, beliefs and feelings which can readily be identified by outsiders, in other words, what people are actually doing; *ideal culture* refers to those ways held desirable but not always practiced.

Would you recognize common reaction patterns that often occur in a cross-cultural situation?

- **Ethnocentrism:** the sense that one's own beliefs, values and lifeways are superior to and more desirable than the lifestyles of others.
- **Cultural Blindness:** the tendency to avoid seeing those ways in another culture that one finds unacceptable or otherwise disturbing.
- **Culture Shock:** being stunned by what one sees in another culture.
- **Cultural Conflicts:** conflicts generated when the rules of one's own culture are contradicted by the rules of another.
- **Cultural Imposition:** the tendency to impose views and values of your own culture upon persons or groups of another culture with limited consideration of their beliefs.

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Understanding the cultural background of your patient has at least three beneficial effects:

- It makes it easier for the patient to approach you ("the nurse will understand")
- It helps you understand what the patient is saying and why, so actions become more comprehensible and predictable
- It makes health care more humanistic and personal, giving greater satisfaction to both patient and nurse.

It is obvious that "awareness of both the differences and similarities among cultures can serve as an important step toward enhanced sensitivity to patients and more effective nursing care."<sup>7</sup> Achieving empathy in a cross-cultural situation is not a simple matter, but it is essential if we are to give holistic health care. ♣

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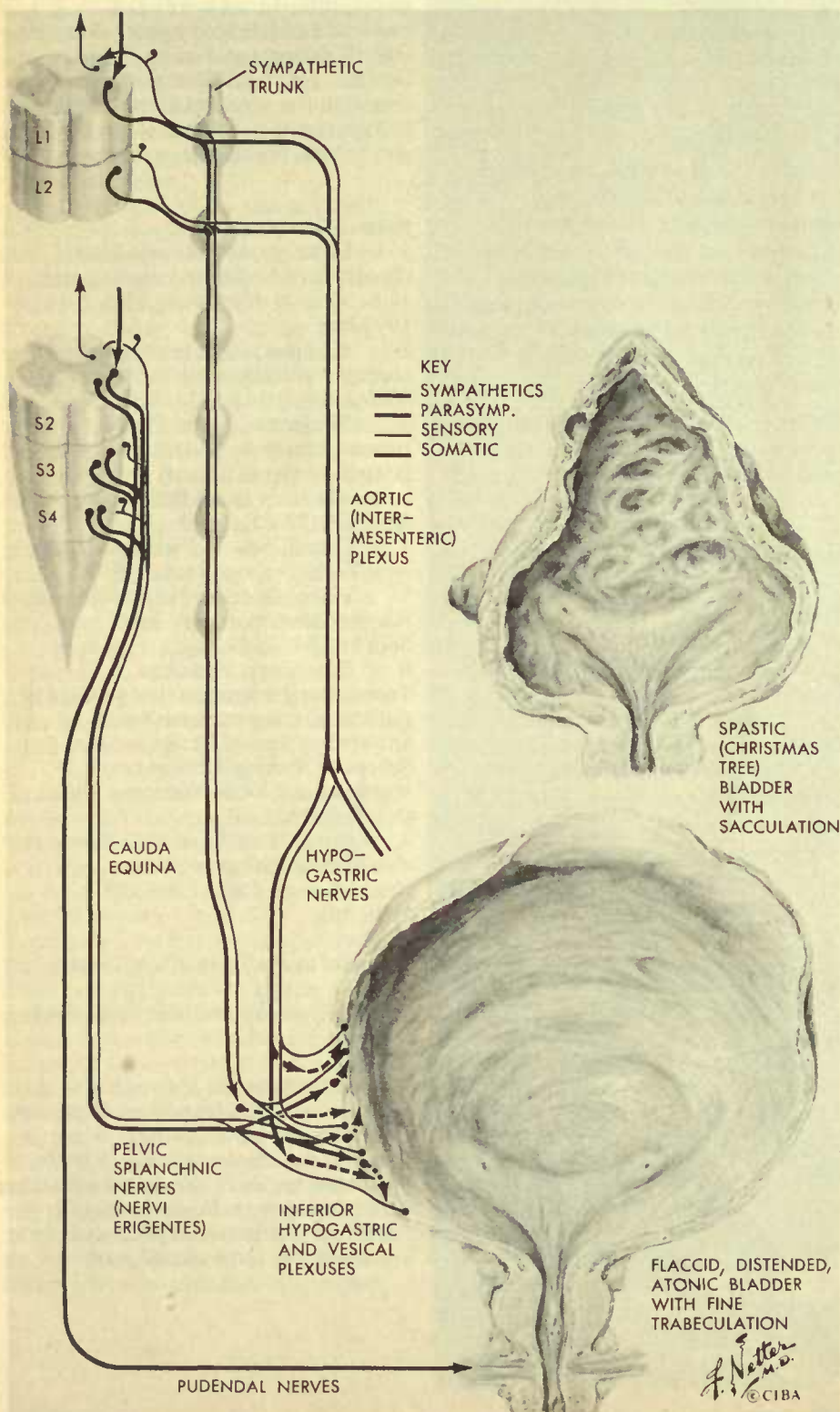
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Corinne Hodgson, an MA student in the Department of Anthropology, McMaster University, Hamilton, Ontario, hopes to complete her studies in June, 1980. In the summer of 1979 she visited outpost nurses in northern Manitoba and the Northwest Territories as fieldwork for her thesis on intercultural nursing.



# Bladder Retraining

Lori Whittington



As nurses in the Rehabilitation Unit of St. Joseph's Hospital, Hamilton, Ontario we first met Mrs. Steen, a 55-year-old widow when she was admitted to our neurosurgical unit; she was worried and very anxious about persistent pain in her right hip, buttock and thigh and queried an increasing right foot drop. The cause of her distress was revealed during a myelogram; an intraspinal lesion was located at the spinal level of L<sub>2</sub>.

We prepared Mrs. Steen for surgery as best we could but no one could tell her what the exact outcome would be. When a laminectomy of L<sub>2</sub> and most of L<sub>3</sub> resulted in the removal of an intradural cyst, we were all relieved. Now we just had to wait along with Mrs. Steen to determine if recovery would be complete; we knew that frequently surgery in this area resulted in a paraparesis due to the inevitable damage of nerve fibers from L<sub>5</sub> to S<sub>4</sub>.

The first 48 hours after surgery confirmed our fears: Mrs. Steen's symptoms of urinary retention, bladder distension and urine overflow were all indicative of bladder paresis and denervation of the external sphincter — a lower motor neuron bladder. We realized we must initiate a program of bladder retraining immediately.

## The Neurogenic Bladder

Neurogenic bladders may be divided into three groups; the type can be readily determined with knowledge of the level of injury incurred. An incomplete injury may produce variable findings. A lesion of the cord less severe than a complete interruption may be only temporary and bladder function may return partially or completely.

### 1. Upper Motor Neuron Bladder

An upper motor neuron bladder is often referred to as an automatic or spastic bladder as the pathways have been interrupted above the micturition center, that is, above S<sub>2,3,4</sub> of the spinal column. With the sacral reflex arc intact and the integrity of the pelvic and internal pudendal nerves unimpaired, the bladder will empty abruptly, independent of the individual's wishes.



Bladder retraining and the technique of intermittent catheterization, now widely used in rehabilitation centers throughout North America and around the world, has been shown to have an excellent success rate in the treatment of neurogenic bladders. Early assessment of bladder function and implementation of a routine is crucial, however, if permanent damage is to be avoided. Consequently, the responsibility lies in the acute care setting where victims of accidents, post-operative complications or cerebrovascular accidents receive their early medical and nursing care. Introduction of a bladder protocol in this setting is mandatory so that, in the weeks ahead, in the rehabilitation setting, complications will be fewer and the chance of success greater.

The amount of urine required to elicit this reflex varies from person to person and is usually related to previous bladder management. Voiding becomes completely involuntary unless the injury is incomplete and then incontinence will vary.

Frequency, urgency and incontinence are the major symptoms of the upper motor neuron bladder. The bladder capacity is usually about 100-300 cc less than normal and since often the bladder contractions are not sustained long enough for complete emptying to occur, residual urine may be present at all times. Stimulation of the areas innervated by the sacral center, that is, the inner thighs, genitalia and the abdomen, frequently will stimulate the onset of micturition. The individual may experience sensations of bladder filling as mediated by the autonomic nervous system; these sensations all indicative of autonomic hyperreflexia include abdominal discomfort, sweating, restlessness, headache, hypertension and bradycardia.

Neurologic evaluation of the individual with an upper motor neuron bladder will reveal:

- absence of voluntary initiation of micturition
- high residual urine, probably due to spastic musculature or decreased efficiency of returning motor neurons
- vesical sensation or sensation of bladder filling is rarely present. In low thoracic lesions some sensory fibers may enter the spinal cord above the level of the lesion allowing minimal sensation
- sensation in the saddle area (perineal area) is absent
- the ice water test is positive. This test involves the introduction of 60 ml of sterile ice water into the empty urinary bladder, in the case of the upper motor neuron lesion there is expulsion of the water
- uninhibited contractions are present, and
- bulbocavernous and anal reflexes are active.

Early bladder management of this condition is critical. If the bladder is overly distended for long periods, it

will eventually require large volumes of urine to stimulate micturition. Conversely if the bladder is continuously drained with an indwelling catheter the muscle will contract resulting in a low threshold for the reflex. Bladder training should be directed at making reflex emptying more efficient.

### 2. Lower Motor Neuron Bladder

Destruction of the reflex arc at the sacral levels, results in the lower motor neuron bladder. While neurologic connections to the brain remain intact, control is lost as the bladder is neurologically isolated from the spinal cord. The reflex pattern via the autonomic and somatic nerves is absent breaking the reflex arc, thus eliminating spontaneous voiding. Denervation of the bladder muscle and the external sphincter results in loss of bladder tone and reflex emptying does not occur. This bladder dysfunction is often referred to as the autonomic or flaccid bladder, as the walls are constantly distended and therefore become flabby. The bladder capacity increases and large amounts of residual urine is common.

Complete lesions below T<sub>12</sub>, congenital lesions as in spina bifida and myelomeningocele and more peripheral lesions of the pelvic nerves all produce this type of bladder dysfunction.

Neurologic evaluation reveals:

- loss of voluntary micturition
- vesical (bladder) sensation is absent
- uninhibited contractions are absent
- sensation in the saddle area is absent
- bulbocavernous and anal reflexes are absent, and
- the ice water test is negative.

Symptoms resulting from lower motor neuron bladder are urinary retention, distension and overflow. Bladder training in this case is aimed at developing methods of emptying the bladder to prevent overdistension and dribbling.

### 3. Mixed type of Neurogenic Bladder

The mixed type of neurogenic bladder is found when the clinical picture

presents a combination of both the lower motor neuron and upper motor neuron bladders. Damage to the cerebral cortex as in multiple sclerosis, tumors or cerebrovascular disease and trauma to the area between T<sub>11</sub> and L<sub>2</sub> result in this type of bladder. As the cell fibers implicated in bladder activity are in close proximity, a variety of symptoms can result and usually include partial sensation and/or partial control. Therapy would naturally depend on the symptoms presented.

### Cerebrovascular Accident and Bladder Dysfunction

A hemispheric stroke results in an incomplete upper motor neuron bladder. The term incomplete is used as the lesion is unilateral leaving the patient with partial sensation and control. Prognosis for such a condition is usually good as the reflex arc remains intact and the partial sensation remaining maintains partial voluntary control.

Brainstem strokes result in bilateral damage to the neural pathways and consequently an upper motor neuron bladder with loss of all facilitation and inhibition of micturition.

For many CVA patients and those suffering from a variety of spinal lesions, a spastic urinary bladder may dominate until after spinal shock is over. Manifestations of this spinal shock may last several weeks and in the case of quadriplegia may persist anywhere from a few weeks to a year or more.

If bladder care during the acute stage is adequate, cord reflexes will recover after spinal shock, making reflex action possible. An indwelling catheter resulting in contraction or overdistension of the bladder for long periods of time contribute to the necessity of prolonged bladder management. Impulses may return to the bladder and prolonged repetitive stimulation of synapses in the cord increase reflex arc effectiveness.

### Complications of the neurogenic bladder

The fact that renal failure is the principle cause of death following



## The Normal Bladder

Lying directly behind the symphysis pubis and below the parietal peritoneum, is the urinary bladder. With its walls consisting of three layers of smooth muscle, commonly referred to collectively as the detrusor muscle, its internal rugae and its highly elastic lining, the bladder is capable of considerable distension for bladder filling. At the base of the bladder, interlaced around the opening of the urethra is the trigonal muscle or internal sphincter, also an involuntary muscle. The external sphincter or urogenital diaphragm, a skeletal muscle, is located just a few

centimeters beyond the bladder and allows the individual control over micturition.

Nervous control of the micturition process is located in three distinct areas of the nervous system. Arising from the second, third and fourth sacral segments ( $S_2-S_4$ ) is the pudendal nerve which controls the voluntary external sphincter and supplies the perineal muscles. Also arising from this area are the pelvic nerves which carry the parasympathetics made up of sensory and motor nerve fibers which relay stretch receptor information and cause contraction of

the detrusor muscle and some dilation of the internal sphincter. The internal sphincter is also innervated by sympathetic motor fibers arising from the upper two lumbar segments ( $L_1-L_2$ ) and probably the lowest two thoracic segments ( $T_{11}-T_{12}$ ). Finally, micturition centers are located in the upper pons and hypothalamus. These centers exert ultimate control over the micturition process. Only when environmental factors are appropriate and the intensity and frequency of stimuli of sufficient intensity is the external sphincter allowed to relax and the bladder to empty.

spinal cord injury illustrates the potentially serious implications of neurogenic bladder complications.

Prevention of urinary tract infections is of primary importance. Inflammation of the bladder increases the activity of the detrusor muscle and potentiates bladder dysfunction. Avoidance of indwelling catheters which provide an entry portal for bacteria cannot be over-emphasized; if a catheter is required it should be changed frequently.

A second complication is the increased tendency to stone formation which can be caused by residual urine in the bladder, decreased weight bearing leading to bone demineralization or an alkaline urine. By decreasing residual urine in the bladder, encouraging activity especially weight bearing to prevent loss of calcium from the bones, and increasing fluid intake to dilute the urine, bladder calculi formation can be reduced.

Vesiculouretral reflux is a complication often caused by overdistension of the detrusor muscle. This back-up of urine into the ureters and possibly the kidney pelvis can result in pyelonephritis and hydronephrosis and eventually to progressive renal failure. This problem can be avoided or alleviated by avoiding large residuals of urine or overdistension of the bladder. If a drainage device is employed, receptacles should be placed below the level of the symphysis pubis.

### Bladder management and retraining

Bladder retraining is utilized in an attempt to establish a functional regular voiding pattern, to eliminate the necessity of catheters and to avoid such urinary complications as infection, retention and incontinence. Before any retraining can be initiated, bladder function must be assessed to determine voiding patterns and the cause of the incontinence. Certain individuals may never become catheter free. Those with

sphincter damage, fistulas, high quadriplegia, advanced multiple sclerosis, multiple myeloma and severe brain damage all present often unsurmountable problems for a bladder retraining program. As well as physiological pathology, mental confusion and urinary tract infection may be causes of involuntary micturition.

The current voiding pattern can be determined by compiling a twenty-four hour record of fluid intake and output over a three to four day period. The amount and time of fluid intake will aid in estimating voiding needs as the sensation for bladder fullness begins at about 250-300 cc. This relationship is verified by the time and amount of voiding. If the patient is incontinent, urine amounts can be approximated, usually a nine inch stain equals 50-75 cc, an 18 inch stain equals 150-175 cc and a 24 inch stain equals 200-300 cc.

Along with this intake and output record, it is helpful to note any awareness of spontaneous voiding or bladder fullness, if there was a feeling of urgency or pain, if straining was necessary, what activities the individual was involved in at the time, if any transient illness was noted, if the individual was under any emotional stress and what position the individual was in at the time (positioning often plays an important role in awareness of fullness and ability to void, in particular the supine position often inhibits micturition).

If urinary tract infection is suspected, bacterial cultures and sensitivity studies should be done. Confirmation of suspicions warrants appropriate antibiotic therapy and in association with this high doses of ascorbic acid may be helpful.

Once voiding patterns have been carefully monitored, the support of those who will help with implementing the schedule must be assured. Family,

staff or whoever is to be involved must be made aware of the importance of uniform implementation of the schedule.

A fluid intake schedule must be established, pushing fluids during the day and early evening and restricting fluid intake after eight in the evening until the early morning. A fluid intake of 2000-3000 cc is recommended.

Offer the bedpan, urinal or take the individual to the bathroom at specific ritualized times on initiation of the protocol. These times should be approximately one half hour prior to the voiding time noted on the initial record of voiding patterns. Once a pattern is established, it can be modified somewhat by providing the opportunity to void prior to the anticipated time. Measures to stimulate voiding may be used.

Evaluation and adjustment of the program should be done regularly, noting whether the individual was incontinent and when.

**The use of intermittent catheterization**  
Intermittent catheterization has proved effective in the management of many types of neurogenic bladders but is especially beneficial in the case of the lower motor neuron bladder. The filling and emptying of the bladder allowed with this type of catheterization facilitates any existing spinal cord reflexes and as well helps to maintain external sphincter control. Introduction of the catheter also stimulates both the internal and external sphincters while an indwelling catheter reduces sphincter tone by holding the sphincters open continuously. The conscious attention paid to the sensations associated with bladder filling and emptying also stimulates the higher brain centers. Other benefits include the avoidance of the complications of bladder dysfunction, ease of sexual relations, improved hygiene, decreased hospitalizations for bladder



## How the bladder functions

During the period of bladder filling, the sympathetic nervous system allows the detrusor muscle to relax and simultaneously causes the tone of the internal sphincter to increase.

The micturition reflex is initiated when the pressure of accumulating urine stimulates sensory nerve endings in local stretch receptors of the bladder, usually as the urine approaches a volume of 250 cc. Afferent pathways through the pelvic nerve conduct these sensory impulses through parasympathetic fibers from the bladder to spinal segments S<sub>2</sub>-S<sub>4</sub>. Motor signals are then transmitted by efferent pathways of the

pelvic nerve back to the bladder stimulating the contraction of the detrusor muscle and the relaxation of the internal sphincter necessary for voiding.

These are known as micturition contractions and are regenerative; that is, one contraction of the bladder stimulates the receptors and the stimulation process occurs over again. However this micturition reflex fatigues quickly and if bladder emptying is not accomplished, the reflex will be inhibited for several minutes to up to an hour before another micturition reflex occurs. As the bladder fills, the reflexes occur more frequently and with greater intensity.

complications and better patient compliance.

### Technique

1. The pH of the urine should be acidic (about 5) to prevent proliferation of bacteria. This can be facilitated with high doses of ascorbic acid (500-1000 mgm Q.I.D.). Cranberry juice taken in large quantities may help decrease the pH in this way.

2. After approximately 300 cc of fluid intake and a suitable period of time, from one to two hours, have the patient attempt to void. Use stimulation of the inner thighs, genitalia and the abdomen if necessary.

3. If micturition occurs, catheterization for residual urine should be done to ensure adequate emptying has taken place. A residual of 75-100 cc is considered acceptable. A higher residual may produce complications such as infection.

4. If the individual is unable to void, catheterize using aseptic technique.

5. Record the amount and type of urine obtained. Send urine specimens for laboratory analysis periodically to ensure that sterility has been maintained.

6. Record whether Crede bladder expression or perineal stimulation were required. Crede bladder expression is a technique used to promote expulsion of urine from the bladder. With hands flat and one on top of the other on the abdomen, firmly stroke inward and down from just below the umbilical area to the bladder until no more urine can be expressed.

*When we recognized that Mrs. Steen's bladder dysfunction was of the lower motor neuron type, it was apparent that intermittent catheterization was the treatment of choice.*

*Accurate daily 24-hour records were kept to provide an ongoing progress report and Mrs. Steen was given one gram of ascorbic acid every*

*six hours to acidify her urine and help to reduce the risk of infection.*

*For Mrs. Steen, bladder retraining took place over a period of about one month. Initially urine retention was high with as much as 650 cc of urine remaining in the bladder after approximately 60 cc had been voided; this initial amount of 60 cc was actually overflow urine. Post-operatively it was difficult to determine to what extent pain, apprehension and positioning were affecting Mrs. Steen's poor bladder performance.*

*Once the amount of the residual urine became less than 100 cc, catheterizations were done only on a daily basis to act as a check on effective bladder emptying. When this was assured, weekly checks were done and finally the catheterizations were discontinued altogether.*

*Naturally, all of this was a great emotional strain for Mrs. Steen. The loss of control was demoralizing and was a great blow to her self-respect; she became impatient with the slow and erratic nature of the retraining method; she wanted to get her bladder "back to normal again". When her residuals remained high or fluctuated drastically she was easily discouraged and often questioned if the treatment was actually going to work for her. We reassured her frequently and, when success was finally attained and she was voiding voluntarily, the excitement made the whole process worthwhile. ♡*

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The cerebral centers, which exert control over the external sphincter, determine when micturition will take place. Cerebral impulses to the motor neurons in the sacral area of the spinal cord cause stimulation of the efferent fibers of the pelvic nerve, resulting in bladder contraction, while other cerebral impulses inhibit stimulation of the pudendal nerve, thus allowing the external sphincter to relax.

Consequently voluntary control of micturition is possible only if the nerves supplying the bladder and urethra, the motor area of the cerebrum and the projection tracts of the cord and brain are intact. Trauma, edema or injury may result in loss of control or urinary incontinence.

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Arriving at a grade which is mutually acceptable to both teacher and student has been a thorny problem for many years. The authors review current literature and research on the subject of grading to bring us up-to-date.

# GRADING STUDENT NURSES

*Vivian Wood  
Joanne Wladyka*

Grading students' work is a difficult task and every grading system used today has its problems.<sup>1</sup> Nevertheless, grading is an important and necessary task for nurse educators. Whether grading tests or clinical performance, nursing instructors feel many conflicting pressures and they are often frustrated by the whole time-consuming process. Grading clinical performance is a job with its own peculiar characteristics and difficulties which have made it a traditional bone of contention among instructors and students alike.

In recent years there have been experiments with non-traditional grading systems and attempts to reduce some of the dysfunctional aspects of grading such as tendencies to elitism. At the same time social and cultural changes have influenced grading difficulties. What follows is a review of some of these experiments and changes in relation to the grading of clinical performance.

## **An educational heritage**

The grade is an abstract symbol that represents an evaluation of student performance. The many shortcomings of the grade have been discussed often; even so, some researchers concede that the traditional methods of grading, although problematic, have no acceptable substitute.<sup>2</sup> Hiner, in his article, "Grading as a Cultural Function", has clearly outlined one of the dilemmas.<sup>3</sup> He describes grading as a cultural ritual and grades as culturally-sanctioned symbols developed to solve the problem of distributing rewards. Thus a grading dilemma exists

because North Americans profess "allegiance to two mutually exclusive criteria for distributing rewards." On the one hand, we pursue individual equality, on the other we value individual achievement and excellence; pursuit of one denies the other. Is there no way out of this? The conflicting allegiances, if not resolved, can whipsaw educators and educational institutions as the negative effects of neglecting one value while upholding the other appear. At the worst, grading systems end up being ambivalent: over the school year they pursue first one allegiance, then the other, then back to the first, and so on.

Hiner refers to grading as a ritual, "...a type of behavior which is stylized or formalized and made repetitive in that form." He points out that while there is nothing pathological in rituals, they must pursue clearly-specified goals, otherwise the means become the ends. He also believes that grading will always be with us because of societal demands, and that the challenge therefore is to make grading work, not to find ways of living without it. To meet the challenge many have experimented with non-traditional grading.

## **Non-traditional grading**

In 1971, a comprehensive study was conducted by the American Association of Collegiate Registrars and Admission Officers<sup>4</sup> which revealed that 41 per cent of the responding colleges predicted a shift toward less traditional grading methods. It is significant to note that at the time of this study, half of the responding institutions were using



traditional grade scale measures, two per cent were using non-traditional grading methods exclusively, and 46 per cent were using a combination of traditional and non-traditional methods. Since most nursing schools in Canada today reside within community colleges or universities, one would expect their grading practices to be similar. A 1970 study conducted by Araneta and Miller found that 44 per cent of the nursing schools surveyed were utilizing the non-traditional "satisfactory/unsatisfactory" grading pattern for both clinical and theoretical evaluation.<sup>5</sup> (The sample size of this second study was only 23 as compared to 1,301 in the first study.) If we interpret the 44 per cent responses as not representing exclusive use of non-traditional methods, their results compare reasonably with the NACRAO study results. These results, while interesting, serve to underline the need for continuing research.

The shift to non-traditional methods was brought about by pressure to provide students of varying capabilities with an equal opportunity to learn; by eliminating pressures created by grades that rank achievement, students are free to maximize individual learning. The conflict with grading systems that emphasize achievement is apparent. Eventually however, the need for recognition seems to prevail and systems are still used which provide ranking. Is the choice which objective do we pursue or, how can we aim for excellence without compromising equality?

### Grading strategies

The changes from traditional to non-traditional grading methods (and vice-versa) reflect, to some extent, changes in social values and student expectations. Both individual choice in constructing an educational program and reduced "competition" in evaluation schemes have been promoted in many ways and consequently, innovation and change in grading methods have occurred. What are some of the newer grading methods being discussed? Several approaches have been prominent including criterion-referenced, blanket, and credit/no credit grading.

Criterion-referenced grading rewards achievement by comparing the student's grades to "some standard established by the teacher of the school".<sup>6</sup> In norm-referenced grading or grading on a curve, the student is evaluated and rewarded in terms of his/her performance relative to that of other students.<sup>7</sup> "Grading on a curve" tells the student he has achieved more or less than some other students, and encourages competitiveness. Supporters of curve-grading state that marks

usually distribute themselves according to the normal probability curve anyway and its use reduces bias or distortion in the distribution achieved; critics say it is not equalitarian and from time to time students have been vocal in objecting to its use.

"Blanket grading" is another approach: in this system all students receive the same grade. A special case of blanket grading — no grade at all — is utilized by some educators who advocate the total abolition of grades. Credit/no credit grading utilizes only two grades — "credit" or "no credit" (pass/fail) either for the reason that more precise grading is not possible or that having more grade ranks interferes with student learning.

The question of which method to use, blanket grading, the traditional A B C D E or credit/no credit, is drawing considerable attention in clinical nursing education. In Dodd's 1978 study, 76 per cent of nursing students and 74 per cent of nursing teachers indicated that they favored the non-traditional "credit/no credit" method of grading clinical performance.<sup>8</sup> Dodd compiled lists of the advantages which the students and teachers saw in this method, including such examples as a desire for greater intrinsic motivation, less competition, less anxiety and frustration and more creativity. Following the initial survey, Dodd implemented a "credit/no credit" grading system in a sample group on a trial basis; midway through the trial period, students and teachers were asked to specify again the advantages and disadvantages which they perceived with their new grading system. The students did indeed note a decrease in anxiety, frustration and competitiveness, and they felt there was an increase in the amount learned. Interestingly however, 49 of the 163 (30 per cent) responding students reported an actual decrease in motivation.

Several studies have attempted to explore the relationship between student motivation and non-traditional grading methods, but there is still no consensus. In one such study, Vernon and Ramseyer divided a class of second semester freshmen enrolled in an introductory psychology course into three groups<sup>9</sup> for evaluation. The traditional A to F scale was used to evaluate the first group, the second group was given a "pass/fail" grade, and the third group was given no evaluation whatsoever. They found that in comparison to the group marked on the traditional A to F scale, the "pass/fail" group studied only half as much and achieved 89 per cent as many correct answers on tests, while the "non-evaluated" students studied only 13 per cent as much and achieved only

63 per cent as many correct answers.

These results contrast markedly with those obtained in another study by Gould in 1978.<sup>10</sup> The study was designed to measure differences in motivation as perceived by nursing students who had been evaluated by both letter grades and a "satisfactory/unsatisfactory" system in their clinical practice. Gould found that under the "satisfactory/unsatisfactory" system, 63 per cent of the sample experienced increased motivation while only 10 per cent of the sample perceived a decrease in motivation. In an article on the subject, Kochman proposes that credit/no credit grading is a solution to the problems created by letter grading.<sup>11</sup> She maintains that this method permits self-paced instruction for student nurses without penalizing the slow learner who brings prior experience to the learning situation. Huckabay, in her study of grading versus non-grading of nursing student performances, demonstrated that using grades to motivate is not necessary for learning to take place and in fact grading may inhibit learning.<sup>12</sup>

The marked differences in results obtained in the previous three studies are typical of the inconsistencies that exist among different authorities on the effects on motivation of using non-traditional grading systems in nursing education. More equalitarian grading methods have not succeeded in resolving Hiner's "dilemma"; we still desire both achievement and equality but they still tend to be mutually exclusive goals. Thus, the use of non-traditional grading methods as a response to social change has achieved, as might be expected, a qualified success at best. Examining the problem in the context of clinical teaching, the problems are exaggerated when evaluating clinical performance since here many traditional measurement techniques are appropriate.

### Grading clinical performance

No matter which grading approach is used in the clinical setting an important focus of the student nurse's attention is still — as one would expect — the grade. In the classroom setting the assignment of a grade can be accomplished by the use of tests and assignments but these alternatives are not easily applied to clinical performance and thus evaluation is more complex. The data collected by nursing instructors are largely influenced by observational methods and are difficult to rank, let alone translate into values.<sup>13</sup> Consequently, the frustrations voiced by both nursing instructors and students are not unexpected. The most frequently expressed concern is the inability of the instructor to give uniform learning experiences to all the students in her



clinical group: the changing variety and mix of clinical clients, the many different unit setups and the large number of personnel to whom the nursing student must adjust in any one setting, form an intimidating list of variables. Also, in the clinical setting the nursing instructor is unable to observe each student continuously. She may have six to eight students to teach, observe and evaluate in a four to six week period. The observational data, at best, are selective and subjective and often there is no clear distinction made between learning and evaluation. Consequently, the student is being evaluated while she is learning, a situation both difficult and undesirable.

According to a study reported by Hayter in 1973, marked discrepancies in grading can be demonstrated among clinical nurse educators.<sup>14</sup> In her study 31 nurse educators viewed a video tape in which three nursing students gave different levels of care to the same patient. The teachers then submitted letter grades for each student. Analysis of these grades revealed an overall agreement rate of only 44 per cent. The teachers were then given a set of objectives specific to the care required by the patient in question, viewed the video tape again, and subsequently completed a checklist which stipulated nursing actions relevant to the case. This time an overall agreement rate of 76 per cent was obtained.

Because of the frustrations associated with the preceding techniques, some clinical nurse educators have been experimenting with "contract grading". "Contract grading", according to Rauen and Waring, utilizes a written, signed agreement between student nurse and instructor for a unit of work to be completed in a set period of time.<sup>15</sup> The agreement specifies the educational objectives and the conditions which the student must fulfill to earn a specific course grade, such as A, B, C, D, or E. Marriner states that the contract helped the students to define their goals and were thus motivated to achieve them.<sup>16</sup> Delaney and Schoolcraft also support use of the clinical contract;<sup>17</sup> in their study, contract grading was tried in a community mental health clinic. The contract was an agreement in writing between the student and teacher as to what grade the student was working to achieve. Minimum expectations were cited for a C grade, and additional activities were required for grades B and A. Some students favored the contract while others did not. The authors state that the contract method reduced the student's anxiety about grades and facilitated objectivity. However, several concerns did arise. Both students and faculty were concerned about the "quantity" rather than "quality" of the

work, the rigidity and time parameters in the contract caused concern and students received a numerical grade which was to be averaged with other grades, a detail which had not been mentioned in the contract.

#### The bottom line

None of the non-traditional grading systems discussed provides a complete solution to the problem of grading clinical performance. This shortcoming is, in part, because the problems exist in the characteristics of the educational experience and not in the grading systems used. We can, however, look to ways of reducing problems which do arise from grading. The instructor must be clear in her mind whether she is evaluating performance or maximizing educational experience. The experimental results indicate that there is no guaranteed way to obtain positive motivation and maximum performance. It would appear that the most flexibility is achieved when precision requirements are reduced. Teachers should remember that overall success is obtained when course design, teaching methods, and testing and evaluation are integrated to achieve specified objectives. Even though clinical teaching encounters difficulties in providing uniform learning and evaluation, by utilizing all the tools available for teaching success the grading problem can be minimized.

The future will probably see an increase in the pressures on the clinical teacher. Student appeals, for instance, are here to stay. Thus, implications exist not only for the practicing teacher but also for teacher preparation. ♦

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\*Unable to verify in CNA Library

*Professor Vivian Wood has written extensively in the areas of assessment for student nurses and analysis of student nurse problems for the Canadian Nurse, Nursing Outlook, Nursing Times, Nursing Papers and the International Nursing Review. She is well known to nurse educators in diploma programs for her numerous workshops on test construction, item analysis, clinical evaluation, the borderline student nurse and the adult student. She is also the author of "Casebook in Nursing Education" and "Teaching Notes".*

*Joanne Wladyka is a recent graduate of the MScN teaching program at the University of Western Ontario in London, and became interested in the topic of student grading during the course of her studies. She is currently employed in nursing education at the Victoria Hospital Corporation in London, and has several years' experience teaching med-surg nursing.*



# HELP!

## Simulated Disaster Game

Nelda Yantzie

When the real thing happens, a disaster is no game! This nurse educator, however, finds that using a game to interest and involve her students is the best way to teach them efficient delivery of health care in an emergency situation.

**CODE 99! CODE 99!** This code could be announced over the public address system of any hospital in any city or town, at any time. It means the hospital's disaster plan has gone into action. Does everyone on staff know what to do? Will widespread panic break out, or will incoming patients be handled safely and efficiently? The success of any disaster plan is directly related to the health care workers' basic understanding of the plan's purpose, principles and organization.

Ideally, before a student nurse completes his or her education, he/she should be instructed in the delivery of health care in a mass disaster situation. This is probably best done in a class organized expressly for this purpose.

The principle objective of such a class would be to communicate to students the importance of a disaster plan, and how to use its ideas to organize emergency care. Other objectives include helping the student nurse to direct activities and assign priorities while under a great deal of pressure, trying to cope with a large number of casualties at one time.

In order to make this learning experience as effective as possible, I felt that there was a need for the students to become directly involved and I developed the game **HELP** to be used as an instructional device.

A class of students was divided into small groups of four or five, with no more than five groups playing the game at once so I could manage to be helpful to all as a resource person. Each group was given the game and a hospital disaster plan for reference.

The method seemed to be very successful: the students became very involved and used the opportunity to develop their powers of judgment, to use problem-solving and assigning priority to needs, to absorb new learning material, and to consider legal implications.

All in all it was an active and fun-filled class session despite the grave subject matter.

### HELP!

#### Directions for playing the game

There are two parts to the game: Part I where injured people are put into ambulances for transfer to hospital; Part II, admission and treatment of the casualties in the hospital.

The game begins by placing buttons with names of the injured people on the area marked disaster site. The object of the game is to treat those people most seriously injured first, and to make sure that everyone needing help gets it. This requires good judgment and fast decisions. Relevant information is given at the beginning of each part of the game.

#### PART I TRIAGE AT ACCIDENT SITE

##### Information:

There has been an explosion at the local cement factory. Three ambulances are dispatched to the site of the accident. The "external triage team" consists of three ambulance drivers, three

attendants, one doctor and a nurse from the emergency department. The injured employees are transported to the hospital in less than 1/2 hour following the explosion.

##### *Employees\* with various degrees of injury:*

Gray, John—age 32 — suspected multiple fractures, labored breathing  
Elliott, Jim—age 45 — superficial abrasions  
Rudy, Clara—age 51 — hysterical  
Austin, Grace—age 29 — lacerated forehead, moderate bleeding, confusion  
Godel, Ken—age 54 — president of factory, history of M.I. two years ago; in mild shock and complaining of tightness in chest  
Case, Frank—age 62 — amputation left leg, shock severe, hemorrhage  
Crane, Mike—age 38 — minor facial lacerations, talking loudly and swearing  
Moore, Otto—age 45 — increasing 'cloudy' state of consciousness, no other injuries evident  
Turner, John—age 54 — dead at site  
O'Riley, Mike—age 21 — deep scalp wound, bleeding profusely  
Hesson, Clark—age 65 — unconscious, egg-sized swelling on side of head  
Deane, Howard—age 48 — deep gash left leg with bone protruding; looks grey  
Hesse, Marg—age 41 — walking around as if in a daze supporting her right arm  
George, Rudy—age 18 — mild shock, burns to arms and back  
George, Rusty—age 18 — no apparent injury other than irritation of his eyes  
Claypole, Walter—age 43 — facial burns, hair and eyebrows singed

*\*Names are fictitious; any resemblance to persons living or dead is purely coincidental.*



# HELP!

## PART I

### START HERE

Place all buttons containing names of casualties and type of injury here.



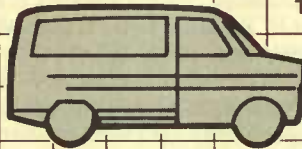
Trip 1



Triage at Site of Accident



Trip 2



To Hospital

Emergency Entrance

### Disaster Site

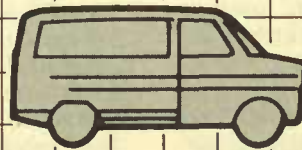
#### EXPLOSION AT A LOCAL FACTORY

Three ambulances are dispatched to the site of disaster. The "external team" consists of 3 ambulance drivers, three attendants, one doctor and a nurse from the emergency department and I.C.U.

Sixteen factory personnel with varying degrees of injury are transported to the hospital in less than 1/2 hour following the explosion.



Trip 3



## PART II

E.R.

E

E

Place the patients (possibly 2 in one ambulance) for the trip(s) to the hospital



S.S.U.  
Ambulatory  
Care

Attention! Code 99 (alert for \_\_\_\_\_)

Morgue

Lab.

Lab.

4 S. Medical  
(2 empty beds)

4 West

O.R.

4 N. Surgical (0 empty beds)  
Mr. Glover  
Mrs. Crozier

I.C.U. (1 empty bed)  
Mr. Boreman, Mr. Cross  
Mrs. Leidke, Mrs. Elderson

3 S.

Radiology

3 N. Surgical (0 empty beds)  
Mr. Caseman Miss Unruch  
Mrs. Ehrodt Mr. Casselman

Stores

2 N. Medical (1 empty bed)

E.R.  
Minor Surgery

E.R.

Nursing  
Office

TRIAGE AREA

Main  
Lobby

Holding area for

E.R.

E.R.  
Fracture Room

Asst. executive  
director

Executive  
director

Physiotherapy

Residence

This area is designated for?



### Move:

One player in the group acts as scrutineer or challenger. The remaining players will be the "external triage team" and will select which of the injured should be transferred first, second, third, etc.

### Note:

There are three ambulances at the site and each ambulance can carry only two injured at one time; each ambulance makes three trips.

### Close attention to Priority of Need is a Critical Element

*Time limit:* 20 minutes

Following placement of injured in the waiting ambulances pause for discussion of rationale in choice.

## PART II MAKING ROOM IN THE HOSPITAL FOR ADMISSION AND TREATMENT OF THE INJURED

### Information:

Within minutes following the disaster, the police notified the hospital switchboard operator of the accident and in turn the executive director declared that the hospital disaster plan be put into effect.

The medical-surgical coordinator and the discharge officer collected the following information regarding the hospital census:

- The emergency department is filled with outpatients for the orthopedic clinic
- There are very few empty beds anywhere in the hospital
- There are some patients who could be discharged or moved to other areas.

### Move:

Select one player to do the writing. The remaining players in the group are the head nurses and the admission and discharge officer who are deciding which of the following patients should be moved or discharged. Show the move by writing (using one color of pen to distinguish the inpatients from the injured) the name of the patient in the area to which he/she was moved. Place an 'X' over the patient's name in the area from which he/she was moved.

### Patients:

I.C.U. 1 empty bed  
Mrs. Leidke — 10 days Post M.I. — condition stable  
Mr. Boreman — 3 days post prostatectomy — condition stable  
Mr. Cross — 2 days post M.I. — condition appears stable  
Mrs. Elderson — 3 weeks post septicemia — temp. stable

### 3 North — no empty beds

Mr. Caseman — 6 days post op, cholecystectomy — condition good  
Mrs. Ehrodt — 10 days post cataract removal, ambulatory — condition good  
Miss Unruch — elective surgery — bunionectomy  
Mr. Casselman — diagnostic tests, gall bladder series

### 4 South — 2 empty beds

### 4 North — no empty beds

Mr. Glover — elective surgery — herniorrhaphy  
J. Crozier — appendectomy, 5 days post op, elevated temp., incision sore to touch

### 2 North — 1 empty bed

*Note:* Remember to use information regarding patient census.

*Time Limit:* 20 minutes

Each player should pause briefly to share with the total group reasons for the various moves before proceeding.

## INTERNAL TRIAGE IN THE HOSPITAL

### Information:

Three ambulances transporting the injured leave the site of the accident — each ambulance makes three trips to the hospital. Mr. Frank Case (see information, Part I) is dead on arrival at hospital, Mr. Otto Moore has become definitely more confused after a short time in the Emergency Room, while Mrs. Austin has become less confused.

### Move:

Continue with the internal triage — the players will receive the injured in the emergency department where the decision is made regarding which area each injured person should be sent for diagnosis, treatment or care.

Using a different colored pencil write the names of the injured into the area where they will be sent.

*Time Limit:* 15 minutes

Players conclude the game by sharing with the total group their reasons for placement of the injured including probable diagnosis, treatment and care.

## Teaching advantages

While the students may enjoy playing this game as they learn, teachers can enjoy the opportunity to evaluate several aspects of their students' performance. Instructors who use HELP have the opportunity to:

- reinforce, challenge or correct errors in judgment
- evaluate the problem-solving ability of their students as it relates directly to judgment and priority of needs
- introduce new learning material related to organization, operation and principles of a hospital disaster plan e.g. triage, communications and directing activities and personnel
- identify legal implications. ♡

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The development of small portable respirators has made a big difference for those with life-threatening respiratory disorders. For Donna, it has meant a second chance, a chance to live at home, to stay mobile and to pursue the goals of her choice.

Eighteen-year-old Donna was initially admitted to the Health Sciences Centre Intensive Care Unit following a respiratory arrest. As a child, Donna suffered many chest infections serious enough to demand hospital treatment. Over time, her exercise tolerance had decreased and her health deteriorated to the point that she required supplemental oxygen at home. On admission to our unit, Donna's diagnosis was bullous emphysema of unknown etiology.

Emphysema is a form of chronic obstructive pulmonary disease (COPD) in which there is distention of pulmonary alveoli to the point of destruction. Loss of alveolar elasticity results in air trapping and increased residual volume, the volume of air remaining in the lungs at the end of a maximal expiration. Progression of the disease may lead to the formation of bullae (air spaces resulting from destruction of the pulmonary lobule). As blood vessels surrounding the alveoli become compressed, serious ventilation-perfusion abnormalities may occur. Emphysema may be caused by irritants such as cigarette smoke and other pollutants, or by such underlying diseases as chronic bronchial asthma and bronchitis. In Donna's case, the specific cause of the disease process was never identified.

Donna was admitted to Health Sciences Centre late at night. She had become so short of breath at home that her parents had rushed her to Emergency, where she collapsed. Clinical and laboratory investigations indicated that she was in hypoxic, hypercapnic respiratory failure precipitated by staphylococcal pneumonia. Several weeks of mechanical ventilation, antibiotics, bronchodilators and intensive chest physiotherapy resulted in considerable improvement in Donna's health. In time, she was successfully weaned from the ventilator, extubated and transferred to the Respiratory Centre of our hospital.

# A Second Chance

Karen Dobson

A few days after transfer however, Donna's infection recurred, her condition deteriorated significantly and she was transferred back to intensive care. Once again she required mechanical ventilation. Her diseased lungs were so badly fibrosed that even brief periods without ventilation were more than she could tolerate; she tired quickly and her arterial  $p\text{CO}_2$  levels rose dangerously. Pulmonary function studies and repeated arterial blood gas results showed that Donna was unable to cope with the abnormally high work of breathing required to sustain her.

Routine medical treatments were no longer adequate to maintain Donna's health. It was evident that without mechanical ventilation, she would die. A tracheostomy was performed. It had to be determined whether or not long term mechanical ventilation was a reasonable solution to Donna's problem.

## Long term mechanical ventilation

It is often difficult to make a decision in favor of long term mechanical ventilation (LMV). The medical, moral and economic implications of such a

decision give rise to considerable thought and discussion. It must be determined whether long term ventilation will improve the patient's quality of life or simply prolong inevitable suffering. Such a decision involves the entire health team, the patient and his or her family. In Donna's case, the decision was positive and so she began a training program in LMV to prepare her to return home and continue her schooling.

For the patient, LMV used to involve years of hospitalization on a respirator or in an iron lung. If the patient could live at home, he would be restricted to a rocking bed or cuirass (a respirator that covers the chest/ chest and abdomen and provides artificial respiration by means of an electric pump). With the development of small portable respirators, however, patients requiring long term ventilation are able to enjoy a less restricted lifestyle.

Portable respirators were first used for victims of poliomyelitis. At the Health Sciences Centre, we have used them successfully in a number of cases: several patients with polio, a young boy with a high cervical spinal cord injury, another with a form of muscular dystrophy. Attempts are being made to adapt the use of portable ventilators to individuals like Donna who suffer life-threatening hypoxia (inadequate oxygenation) and/or hypercapnea (excessive carbon dioxide retention) and cannot maintain an abnormally high work of breathing.

At the Health Sciences Centre, we use several different ventilators for long term mechanical ventilation. They are small, compact machines that can be mounted either on the back of a wheelchair or, for ambulatory patients, on a pushcart.



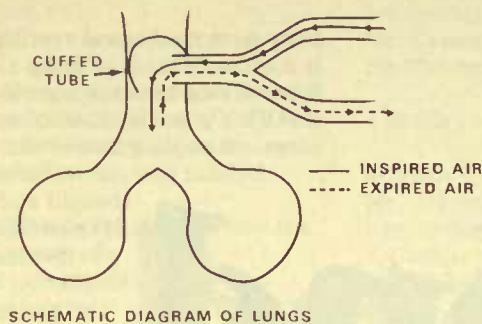


Figure one Conventional respirator with cuffed tracheostomy

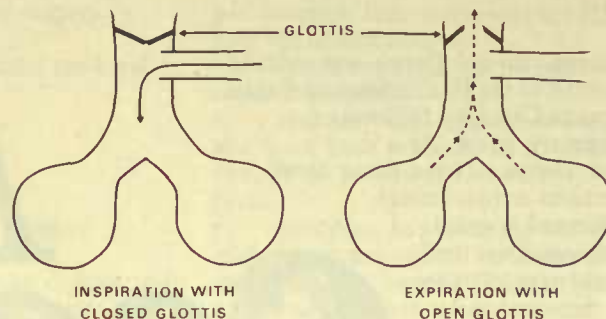


Figure two Portable ventilator

The mechanics involved are quite simple. These ventilators have a motor-driven piston that can be set for various volumes and rates of respiration. They can operate for 12 hours on an external 12-volt golf-cart battery, up to one hour on their own internal rechargeable battery and they may also be plugged into any 110 AC outlet. Alarms signal high pressure, caused by coughing or excessive secretions; low pressure, denoting disconnection of the tubing; or low voltage, for AC and DC power failure. In cases of AC power failure, they automatically switch to DC power. Some machines fit into a portable carrying case resembling a small suitcase and weigh about 11 kilograms or 24 pounds.

#### Learning to breathe

Portable ventilators are designed to operate on room air. For this reason, our training program aims first of all to ventilate the patient on room air. If supplemental oxygen is a must, it can be added to the inspiratory tubing from a portable oxygen tank. Although it is difficult to determine how much oxygen is in fact being delivered to the patient, oxygen may help relieve a certain amount of hypoxia. However, the additional weight of an oxygen cylinder reduces the portability of the ventilator. Donna requires two to three liters of oxygen for sitting or sleeping and she turns the flow rate up to seven or eight liters when she is walking.

Our second step is to help the patient make the transition from a cuffed to an uncuffed tracheostomy tube. An uncuffed tracheostomy tube allows the patient to talk, which is a considerable advantage.

The cuffed tube, used with conventional respirators, forms a seal in the trachea (see Figure one). Air not only flows in but also out of the lungs via the tubing. Portable ventilators, however, do not always require an expiratory line and therefore the tracheostomy tube must be uncuffed; the patient exhales through his mouth and nose (see Figure two).

This means that the patient must learn *glottic closure*. Donna had to learn to close her glottis as she began to take a breath so that inspired air flowed into her lungs and did not escape through her mouth and nose. She describes this skill as "swallowing before each breath". During expiration, she must allow her glottis to open in order to exhale through her mouth and nose. These techniques were among the most difficult for Donna to perform, especially while she was sleeping. Practice soon makes glottic closure a subconscious maneuver except in deep sleep, when inadequate ventilation may result.

Those who like Donna have an obstructive lung disease have a more difficult time adapting to a portable ventilator than do individuals with neuromuscular problems or normal lungs. This is because COPD patients have a variety of chronic pulmonary problems which often contribute to an increased resistance for the respirator to overcome in delivering the prescribed volume of air.

For example, patients with COPD often have increased secretions. These secretions not only increase resistance to ventilation but also create hygiene problems and potential risk of infections. Glottic closure against high pressure is another problem COPD patients may encounter. In addition, they often need a prolonged expiratory time to deflate their lungs effectively and may have difficulty adjusting to the ventilator's 1/1 inspiratory-expiratory (I/E) time ratio. The simplicity of these ventilators, necessitated by their portability, makes it impossible to adjust the I/E ratio. Donna stated that she sometimes felt as if she was "blowing up" until the rate was slowed, allowing her more time for expiration.

At first, Donna practiced on a conventional respirator set on the control mode. Each day, the cuff on her tracheostomy tube was deflated while she practiced glottic closure. She also learned to eat and drink with the cuff deflated and to speak on expiration as air flowed out over her vocal cords. Once she had learned these skills, an uncuffed tube was inserted and Donna made a permanent switch to the portable ventilator.

An uncuffed tracheostomy tube also allows the patient to take extra breaths through his mouth and nose between respirator breaths. It must be stressed that the patient cannot assist or trigger these ventilators; they are a 'control' mode only. If more than the prescribed volume of air is needed, the rate of the machine must be increased.



### A team approach

A variety of health care professionals is involved in preparing a patient to go home on a respirator. Of these, nursing staff spend the greatest number of hours teaching both patient and family.

Donna was taught to suction herself, to do her own tracheostomy care and to operate the respirator. Chest physio was also taught in the program. Family members were included in the teaching sessions so they could manage treatments if necessary. The amount of work that the family is required to do varies according to the abilities of the individual patient. Donna, for example, has no neuromuscular disorder and can do a great deal for herself, whereas many patients on LMV have little or no use of their limbs and are totally dependent upon others.

Physicians, physiotherapists and respiratory technologists are very much involved in the process of assessing, teaching and preparing the patient for discharge. Home visits must be made by members of various departments to ensure adequate preparation and to assess the need for modifications in the patient's home. Wheelchair ramps or handrails may be necessary and alarm systems are often installed. Suction equipment is also essential.

Nursing staff and a respiratory technologist usually accompany the patient home on several occasions before discharge. The patient and family become very comfortable in the protected environment of the hospital. Without supervision and guidance, the patient's discharge can shake the family's confidence in its ability to deal with situations as they arise. Home visits can help family members with real management problems and help them make necessary changes.

The home care department plays a large role in ordering supplies and arranging for their pickup and delivery. Respirator tubing and humidifiers must be changed daily and returned to the hospital for sterilization. Patients themselves must return to the hospital every seven to ten days for tracheostomy tube changes until family members are able to do this task. Home visits by nurses are arranged as needed. Financial assistance is adjusted according to each family's medicare coverage and other health insurance.

### Home again

Donna's ventilator is mounted on a four-wheeled cart along with a 12-volt battery and oxygen cylinder; she wheels this cart ahead of her as she walks.

Transportation out-of-doors can pose another problem: for those confined to a wheelchair, a van or bus is needed. Donna's parents are able to use a truck camper in the summer. In the winter, they remove the back seat of their car to allow room for the respirator cart. Donna sits in the front seat, with her respirator tubing running over the back of the seat. A van transports her to and from work.



The psychological impact of LMV is tremendous. For a young teenager, the change in body image alone can be devastating. Donna states that one of her biggest problems was the stares and whispers behind her back. She says, "I was worried about what my friends would think. But they have been really helpful...and now, I think they have accepted me as I am."

Donna also expresses frustration at her lack of independence. She is unable to drive a car any more and so must rely on someone else for transportation. Donna now has completed her Grade 12, and has a part time secretarial job. She has her own apartment, closely supervised by her family. The weight of her ventilator and cart makes it difficult for her to move up and down stairs by herself, thus limiting her mobility.

Often the patient's family finds it difficult to accept all the changes that have occurred and require a great deal of support and guidance from hospital staff. As for Donna's parents, they are grateful that she does not need to be institutionalized, that she has some degree of independence. Although they admit to becoming very tired, especially during times when Donna is ill or unable to sleep, they are coping well.

Donna is a very cheerful, friendly girl. In spite of her disability, she received an award from her school for her contributions. She realizes that her disease process is ongoing, and that her predisposition to chest infections may well determine her eventual prognosis. Donna is determined to live her life to the best of her ability and to cope with problems as they arise.

It is evident that LMV is neither a possibility nor a choice for every patient with a life-threatening respiratory disability. Certainly the patient's age, general health, outlook and support systems must be considered carefully before undertaking such a course. But for patients like Donna, the portable ventilator has meant a second chance, a chance to live at home, stay mobile and pursue her goals. A few years ago, such a choice would have been impossible. ♡

*Karen Dobson, RN, is a 1975 graduate of the St. Boniface General Hospital School of Nursing in Winnipeg. She completed the Winnipeg Health Sciences Centre post graduate course in intensive care nursing in 1978 and is presently an instructor in the same program. It was in the ICU that she became involved with Donna and the LMV program that allowed Donna to return home.*



# Nursing in a university health service

*Florence Tracy*



*Photo courtesy Gigi Villafior*



Working as a nurse in a university health service, as I have for the past 12 years, definitely places me on the "frontline" of health care. It also offers some unique challenges in understanding the dynamics of human growth. Do students really present problems that are unique to this setting and population?

Most definitely. In our health service, for example, almost all our clients are adolescents and young adults. In addition to any medical problems they may have, most of them are also learning how to cope with the pressure of their studies, problems involved in relationships with their peers, rebellion against their parents and other authority figures, and, often, their first taste of living away from home. Sometimes they find the university setting a threatening place — professors, advisors, the whole bureaucratic system seems far removed from their personal concerns and needs. These are difficult years for them: their inexperience, often coupled with unrealistic parental expectations, makes mistakes inevitable and the need for counseling imperative.

At McGill, the University Health Service is under the direction of the dean of students and the staff includes two internists, three general practitioners, a gynecologist, a surgeon, a dermatologist, two psychiatrists, two psychologists, four nurses, an x-ray technician and a lab technician. Students are encouraged to visit the health service before minor complaints escalate into something more serious. A non-threatening, informal atmosphere is established through an open door policy, appointments are not required and rarely does a student have to wait longer than five to ten minutes to see a nurse who assesses the problem and makes the appropriate referral.

The University population is very aware and present-oriented; they want understanding, they want action and they want reasons for why things are happening. They are happier and more at ease when they leave the service if I have spent 15 minutes discussing with them the treatment of the common cold, than if I had simply handed them a patent medication. They appreciate the helper who goes the extra distance, who sees beyond their immediate question or symptoms, who shares some of the responsibility with them and, quite possibly, makes a return visit



unnecessary. They are also extremely up-to-date and easily influenced by popular literature on fad diets, birth control measures, etc. Long before this product was marketed in Canada, I received phone calls about the vaginal suppository contraceptive, Encare Ovals®. The same day that an issue of Time magazine printed an article on non-gonococcal urethritis, I received a call from a student asking the difference between NSU and NGU and whether he had been properly treated, because his treatment was different from that described in the article.

When a student visits us with a problem, we try to capitalize on this visit and help him in other areas. The young man who comes in with a sprained ankle and who also has a severe acne problem is asked if he is seeing a doctor for his skin problem and if he is not, we offer him an appointment. In the same way, we ask the girl we treat for monilial vaginitis whether she is aware of birth control information that we can give her if she needs or wants it.

Although this age group appears on the surface to be very sophisticated and knowledgeable, this is usually not the case: they know the words but have just as much difficulty as their parents before them in working out answers or asking for help. Last year a young female student in her early twenties came to see me. She said that she and her fourth year medical student boyfriend had developed a very close long term relationship and had decided that they were ready for sexual involvement but neither had much knowledge of birth control. As difficult as it is for most of us to understand and although the information is readily available, many young people still have difficulty translating this information into their own lives.

Teaching self-responsibility for health and the awareness that body and mind must work together to maintain a healthy equilibrium is how we attempt to teach prevention. It has been my personal experience that teaching on a one to one basis is much more effective on campus than attempting to organize groups. We try to capitalize on the time that students spend waiting for appointments or waiting after allergy injections. Most students do not realize that stresses from school work or personal relationships can be expressed physically through headaches, a missed period, eczema or, conversely, the reason they are not doing well at school may be due to a lack of good health.

They often fail to make the connection between their woefully imbalanced diet and their colds, infections, fatigue or depression. We can teach students to take care of themselves not through formal lectures or through abstract principles of nutrition but through practical informed advice.

A student at the center for an allergy shot, for example, joined in a discussion on nutrition I was having with one of the other students. As it developed, the allergy student had had only one serving of vegetables during the past week. Poor diet is rarely caused by lack of money although this is the excuse we most often receive. More often, it is lack of information, poor planning or just plain bad eating habits. What we must do is translate the principles into everyday language to meet the specific needs of the particular student we're talking to. It is not that the students are cognitively unable to do this, but at times they need someone to do it for them first, to show them the way. With this comes the knowledge that someone really does care about them.

Frequently the medical problem is minor or non-existent, the student doesn't know what is wrong, only that he "just doesn't feel right". Recently, a young man visiting the clinic for treatment of venereal disease appeared increasingly distressed and anxious on each succeeding visit. He seemed unable to discuss what was troubling him with any of the staff, including the physician. When I asked him directly why he was so upset, he replied that he was worried because he had V.D. I reassured him that the antibiotics were going to clear that up and that it really wasn't worth what he was putting himself through. After much discussion, he explained that he and his girlfriend had been dating seriously for two years but had not felt ready for a sexual relationship. On a weekend with some university friends, however, he had been pressured by the group to join in on group sexual activities. The result had been the V.D. He recognized that most of his friends were sexually active and was now questioning whether there was something wrong with him, since he had sexual fantasies and dreams but still felt no need for sex within his relationships. I reassured him that young men often have very strong sexual desires and frequently fantasize these; he and his girlfriend should enjoy their

relationship and, when they felt ready for more physical involvement, they could then approach it with maturity. When he left much of his anxiety seemed to have been relieved. A few days later when he returned to see the physician, he poked his head into my office and asked "You're sure it's O.K. if I *don't* want to?" I reassured him again and he was on his way with a smile.


Over the 12 years that I have worked at the health service, I have noted a phenomenal increase in the number of problems related to stress and anxiety. Often it is difficult for a young person to recognize what is happening or to realize when he can no longer cope and needs help. A very rational and aware medical student that I had been seeing regularly for allergy injections came in one day, stating that he did not know what was wrong or why he was acting the way he was. "I did not know where to start so I came to see *you*" he said. Because I was accessible, he had someone to talk to and he received early psychological assistance for an acute anxiety reaction.

The role of the nurse as a supportive figure in the student's life extends beyond the health service. Attending a play or a recital, reading and remembering to comment on articles written about or by the student, is I think as important to the student's general well-being as the other kinds of caring we can provide. For some students, weekends are particularly difficult periods because the structure of regularly scheduled classes is missing. Just knowing that there is someone available to talk to, even for a few minutes on the phone, is important. As one student wrote, in a note of appreciation she sent to me following a period when she needed help in overcoming self-destructive behavior, "For being there and being real, thanks." ♡

*Florence Tracy, RN, BA, a graduate of the Queen Elizabeth Hospital School of Nursing, Montreal and Concordia University, Montreal, is currently nursing coordinator at the McGill University Student Health Service and has recently been appointed Warden of Royal Victoria College, McGill University.*



# CARP



## A New Way To Learn

Margaret E. Murray

**Year after year, the staff at Toronto General Hospital had been plodding through the same mandatory safety review, yet unsafe practices were still evident all over the hospital. Last year, the staff development department vowed they would make the annual review more interesting...and successful.**

CARP, or the Combined Annual Review Program, was the child of a marriage between basic principles of adult education and a new concept of presentation; it was born out of a desire to relieve the monotony of yearly reviews of accident prevention, fire evacuation, electrical and medical gas safety.

Part of the problem was that our staff often felt the subjects of the annual review were either self-evident or too complicated — a waste of time either way. Since many had already “had it”, they didn’t feel that they needed “it” again. However, the continued use of unsafe electrical equipment, unsecured oxygen tanks on stretchers and wheelchairs, plus an increased employee accident rate indicated the contrary — the staff definitely needed this information, but how to make them aware of their own need, and how to get them to retain what they learned?

There is a story about a teenaged girl who stood at a window repeating quietly “Tom, Tom, Tom...”; when her mother asked her what she was doing she replied, “They told me at school that if I used a word ten times it would be mine.” We in staff development had fallen into that very trap, believing that word-perfect recitation of information from the staff meant real internal comprehension. What we had been doing in fact was presenting a given amount of information to a passive audience without realizing that much of it would probably be forgotten. All that remained for staff and teachers alike, was the dubious satisfaction of having gotten through it for another year. We began to think there had to be a better way.

Principles of adult education tell us that people learn best at their own pace, according to their perception of the importance of the material, and by relating it to past experience. Because of our wish for the staff to acquire a basic core of content, we had organized a single homogeneous presentation, but it was unlikely that this was suitable for all. Learning theories suggested too that actual experience is ideal, but it seemed slightly impractical to us to set fire to one of our buildings merely to test our efficiency at evacuating patients, or to electrocute someone to emphasize the importance of electrical safety. In some areas at least, cognitive experience would have to suffice.

But experience was the key word. We had identified the first part of our problem as the need to make staff aware that their knowledge was inadequate. While we could not involve them in a real situation, we could ask questions which would help them assess their own knowledge of content. We felt that the use of short questions, combined with visual displays and the availability of teaching staff as resource people, would lead to successful internalization.

Further, if this new method would work for one subject area, why not for all of them? We could condense previously separate programs into a single entity; three months of dreary repetitive classes could be transformed into three weeks of involved participative learning!

We anticipated stumbling blocks, and we found them: “The idea is so different, will anyone accept it?” “How will we schedule it so everyone can come?” “How can we staff it?” “How will we know if anyone has learned anything?”

### Putting it together

First we devised the questions, which were to be organized into a ten-page booklet. We decided short answer, multiple-choice and match type questions would be the best and we wanted the questions to draw on the basic knowledge needed by a safety-conscious bedside practitioner. Questions ranged from generalities such as “List five steps you would take if you discovered a fire in the hospital,” to specifics such as “What are the two most common causes of employee accidents in this hospital?” Some questions were complex such as “What is alternating current, and what is direct current? Why is AC more dangerous than DC?” While the nurse is not expected to be a handyman, she should be acquainted with potential hazards and know safe ways to deal with them until help arrives.

Once our booklet was organized, we commissioned the most artistic member of our teaching staff to design a cover page using her imaginative goldfish symbol; we then stunned the hospital printing department with a request for 1500 copies!

Program presentation involved a few more problems. We needed one room large enough to house four separate displays (one for each subject area of the annual review) and to accommodate the 30 to 40 people who would be working in it at any one time. Suddenly, realizing we had to work on our visual displays as well, we felt like a department store at Christmas with four huge empty windows to fill. What could we put in the displays that would be both stimulating and educational?



For Accident Prevention we envisioned a series of posters dealing with the causes of hospital accidents and the resulting costs to both institution and individual employee. Our statistics indicated that back injuries and needle pricks were responsible for the majority of reported incidents in the Nursing Department, so we concentrated on body mechanics and the handling of sharps. Although we felt the principles in this case were well known, the prevailing attitude among staff was, "it won't happen to me." Basically, this would be an exercise designed to increase awareness of hazards and stress the need for prevention. The Ontario Hospital Association graciously supplied us with safety buttons to carry the message throughout the hospital, and excellent pamphlets dealing with techniques for moving patients without backstrain.

The posters for Medical Gas Safety concentrated on a review of fire safety with regard to oxygen administration and particularly on the necessity for securing all cylinders to prevent them from falling. The number of people who were unfamiliar with this latter danger was very revealing; even those who knew of it spoke vaguely of the hazard as an "explosion". We used the analogy of releasing an inflated balloon without tying off the end to illustrate what can happen to a highly pressurized cylinder when it develops a leak. The image of a highly erratic, five-foot-long, solid steel projectile was, to say the least, sobering.

We obtained large and small oxygen cylinders with appropriate stands and transporting devices to demonstrate and reinforce the correct way of handling this equipment.

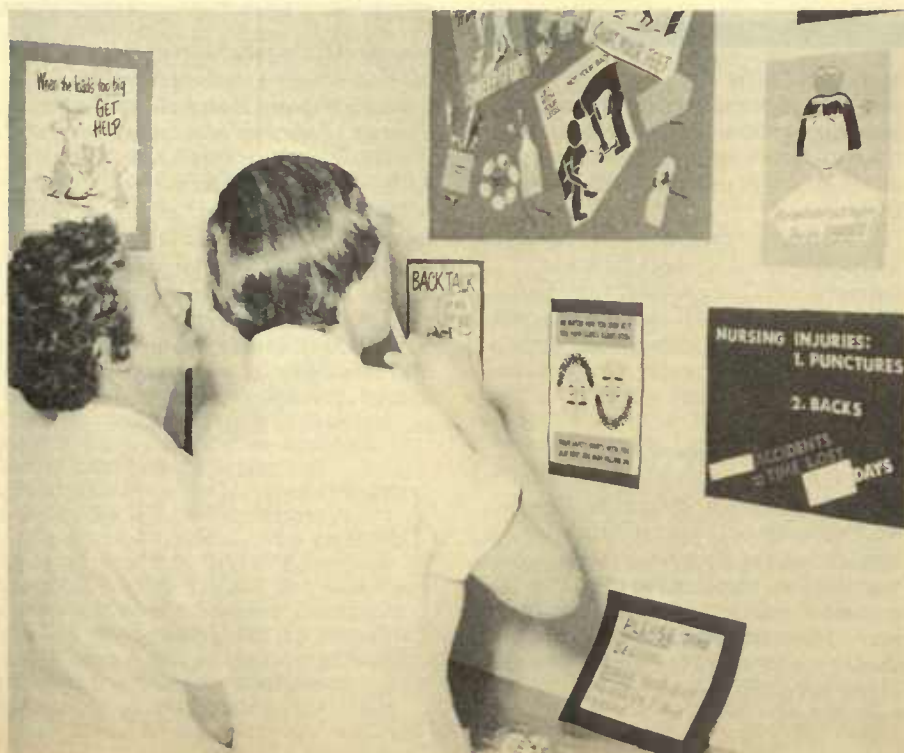
The Fire Evacuation display required the greatest amount of physical participation. We decorated the wall with cartoon reminders of the principles of fire safety, and displayed the hospital's Fire Safety Manual as a resource. We borrowed a film called "Code 1001" which demonstrated the most practical lifts and two beds for a practice session held afterwards. Since psychomotor skills become rusty with disuse, we expected all able-bodied staff members to practice. Inevitably they were rather reluctant at first, but usually became willingly involved with a little encouragement. Besides giving us a chance to reinforce body mechanics, it introduced a needed physical component into a mainly intellectual exercise, and produced more than a little merriment.

Electrical Safety was the most complicated and least understood area, but also the area of our greatest resources. Within the past five years, our hospital, together with Ontario Hydro, had developed a comprehensive series of slide/tape programs dealing with Electrical Safety in the general ward setting, in the Operating Room and in the Intensive Care Unit. These were too extensive to be used in their entirety in our review so we selected a portion of the general ward program which dealt with the basic minimum of electrical theory needed to safely operate any electrical equipment. What is voltage?



What is current — both alternating and direct? How can you protect yourself against the effects of electricity? What should you do if you see someone being electrocuted? These were only a few of the questions addressed in this part of the program, and the answers were directly related to home or hospital situations with which the staff are quite familiar. Considering Canada's heavy dependence on this form of energy and the casual way in which most of us handle it, it is either an inherent tribute to the safety standards of the electrical industry or a miracle that there are not more accidents. We attempted to make the staff realize that the familiar household tabby is in fact a full-grown tiger, to be used and handled with respect.

We conducted two separate sessions with the Operating Room staff to illustrate the operation of the cautery machine and to stress the cause and prevention of cautery burns. An I.C.U. program was offered as well to all I.C.U. staff on a separate basis after CARP was finished. Basically it was an extension of the principles of the general program, but it outlined why patients in I.C.U.'s are often more "electrically sensitive" than other patients and hence why a working knowledge of electrical hazards and safety precautions is especially important. Several posters and a few visibly damaged electrical items rounded out this display.





Refining these concepts and putting them to paper in imaginative form was both the most difficult and the most interesting part of planning CARP. In addition to working on posters, which we did for many hours, a flyer announcing the program had to be prepared, and arrangements made for classroom facilities and audiovisual equipment.

One major concern was the head nurses' reaction to our proposal. Although the Nursing Executive Committee had accepted the idea, we knew that only a brave inservice instructor would ask a head nurse to release her staff for one and a half hours to attend the review. To our surprise, when we presented our best arguments at the administrative staff meeting, the

Staffing the review program was relatively easy: we asked for a moratorium on all other programs such as orientation until CARP was finished, and we divided the thirteen hour time period in which CARP would be open into three overlapping shifts, leaving a fourth teacher free to continue with the regular bi-weekly inservice classes.

One last question remained: how could we know if anyone learned anything? Unfortunately, there is no way to objectively evaluate this, but we had several indications that were highly encouraging. First, the attendance figures soared to an astonishing 75 per cent of all staff (the usual was 50 per cent), and the level of pre-class participation was unexpectedly high.

Even without solid objective proof, the presumptive evidence indicates that something good happened with CARP; the marked increase in attendance and the lively participation were all important.

For us in the staff development department, CARP opened a door. It was our first adventure in providing self-acquired learning, while attempting to replace monotonous repetition with active participation. It was as much a learning experience for us as for the rest of the staff, and appears to have been highly successful. CARP has left us with a feeling of satisfaction, a host of new ideas and a taste for more experimentation in non-traditional teaching methods: no small accomplishment for a humble goldfish. ♡



Photos courtesy of Toronto General Hospital

#### Resources

*Electrical Safety in Hospitals*, a slide-tape program co-produced by Ontario Hydro and Toronto General Hospital.

*Code 1001*, a film produced by Baltimore County Fire Department, available in Ontario from the Ontario Fire Marshall's office, Toronto.

Pamphlets: *Techniques for moving patients*

*Basic Guide for safety*

*Your safety in nursing*

*Accident prevention with wheeled equipment*

available in Ontario from Ontario Hospital

Association, Don Mills, Ont.

Hospital Accident Prevention Department.

head nurses seemed quite receptive. The prospect of resolving three months' worth of programs in three weeks' time outweighed the negative aspect of losing staff for 90 minutes at a time. A point in our favor was the fact that we did not assign specific class times; rather, we held the program open from 0800 to 2100 hours for three days a week, thus allowing staff to come at their convenience, when it was safe for them to leave their particular units. (If night staff did not happen to rotate onto days in this time, they were encouraged to come on their own as they would be given time off in lieu later.) The booklets could be given out two weeks before the program, and we emphasized that those who answered whatever questions they could in advance would complete the review in less time.

Many staff nurses said they had canvassed husbands or just friends in general to get answers to the questions in the booklet. Others had been involved in group efforts during quiet periods on their units.

During the program, staff displayed a visible interest in checking the correctness of their answers and in finding the answers they hadn't known. Often they worked in two's and three's, helping each other and turning to us only when they were really stuck.

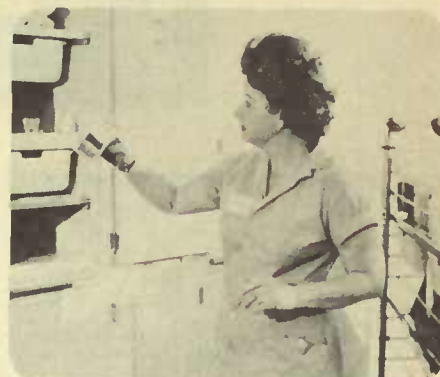
#### Something good happened

After CARP was completed, we scanned random booklets to determine the areas which presented the most difficulty. As anticipated, the Electrical Safety section was still the subject of the most confusion and misunderstanding. The second time this program is run, we should see an improvement if there has in fact been any real increase in knowledge.

**Margaret Elizabeth Murray** is a graduate of the Atkinson School of Nursing, Toronto Western Hospital, and has a diploma in nursing education from the University of Western Ontario as well as a BScN. She has worked as a staff nurse in both med-surg units and the operating room in hospitals in Saskatchewan and Alberta, as a surgical co-ordinator in Saskatchewan, and for the past ten years she has been a teacher at the Toronto General Hospital. For three years she taught nursing students at the TGH School of Nursing, and for the last seven she has been in Staff Development.



# Gordon Friesen



## On the side of the angels

Anne Besharah

Why is the patient always the last one to be consulted in any plans to improve hospital services? Why is the nurse the low man on the totem pole of providers of health care? Why does she sometimes spend as much as half of her eight or twelve hour shift away from the bedside, finding the supplies she needs to give care? If Gordon Friesen had his way, none of these situations would be allowed to exist.

Gordon Friesen has been preaching enhancement of the status of professional nursing and a patient-oriented approach to the delivery of health care services for the past fifty years. Now, as he enters his seventh decade of life, he is beginning to see the results of his long crusade: many new hospitals around the world have been built to his specifications, hundreds more have been modified to embrace the concept that "planning must precede form and both must bow to function".

Gordon Friesen is retired now, after a long and sometimes controversial career in hospital administration that began when he became business manager of the 300-bed Saskatoon City Hospital at the age of 21, and ended with the establishment of his own independent health care consulting firm, Gordon A. Friesen Incorporated International in Washington, D.C. Along the way, he has received recognition at home and abroad for his innovative approach to health care administration and construction; he has lectured at universities in the U.S., West Germany, Australia and Canada, given presentations at the U.S. Naval School of Hospital Administration and acted as consultant to the Surgeon General of the U.S. Navy, Army and Air Force. In 1970, he received an Honorary Doctor of Laws from George Washington University in Washington, D.C., and today he continues to receive requests

from universities and other groups to lecture and take part in panel discussions and conferences.

For nurses who come to work in a "Friesen hospital", the first and most obvious difference in design from traditional structures, is the absence of the familiar nurses' station. The administrative control center (ACC) which replaces the nurses' station is staffed by a clerk who coordinates all administrative functions thus permitting the nurse to go from room to room without returning to home base. The nursing team (during the day shift usually consists of Two Registered Nurses, a Technician and an Aid) remains in a twenty-bed zone of which there are normally four on each floor.

Another key element of the Friesen design, is the "Nurserver", introduced simultaneously in the early sixties in three institutions — the American-British-Cowdray Hospital in Mexico City, St. John's Mercy Hospital, St. Louis and Holy Cross Hospital in San Fernando, California. The Nurserver completely isolates clean from contaminated supplies, it promotes better patient care by reducing unnecessary traffic in and out of patient rooms (a primary Friesen concern later approached through other innovative corridor concepts); by assuring a daily restocked supply of patient needs including medications, it basically eliminates requisitioning and contributes to the Friesen goal of permitting the nurse to devote the maximum possible time to her primary objective — nursing the patient.

Friesen is convinced that the professional nurse should be available to the patient 100 per cent of the time, which means that everything she needs must be placed at her disposal. In order to implement this philosophy, he has eliminated the traditional nurses' station and made each patient's bedroom, in effect, a nursing station containing its own service area and all other appurtenances required for daily

patient care. This cuts down nurses' "travel time", professionalizes the major portion of their work and facilitates the organization of the nursing staff into teams — a basic part of the implementation of his plan.

By the year 2000 the acute hospital as we know it today will have disappeared. In its place we will have Regional and Community Centres where all health care will come under one umbrella, including preventive medicine. The larger health facilities of the future will make better use of automation by placing everything that the doctor or nurse needs (except the patient) on the production line. This concept is just as applicable without automation in smaller health centers where the supplies are delivered manually. Food should be available when the patient is ready to eat, and by sending it to the patient's floor in a frozen state and preparing the tray in the galley for each zone makes this concept possible and logical.

And what does the future hold for nurses? Gordon Friesen has a twinkle in his eye when he replies, but there is no doubt in his sincerity: "I love nurses. They must be kept on the highest professional level making sure they are recognized as an important part of the medical team. The role of the nurse is to nurse, to treat the patient as a whole respecting his or her dignity as a human being. With such qualifications and a functional health centre will come improved quality of care and efficient organization. This is the objective for the year 2000."

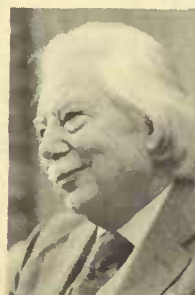


Photo of Gordon Friesen by Studio Impact, Ottawa.



# Introducing New they stay twice

## Why It's Better for Baby

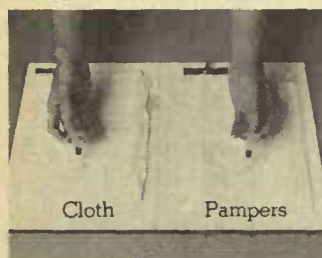
### 1. Softer surface next to baby's skin

- ☐ Embossed topsheet looks and feels softer... reduces skin contact and increases separation of skin from moisture in pad.

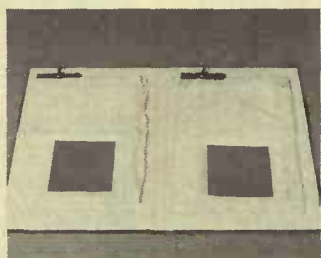
### 2. A drier, more comfortable baby

- ☐ Polyester fibre topsheet is more hydrophobic... does not absorb fluids itself but encourages passage through into absorbent padding below... resists backflow.
- ☐ Stronger absorbent pad with stronger tissue envelope... provides 225 percent more wet strength for a 60 percent reduction in tearing and shredding.

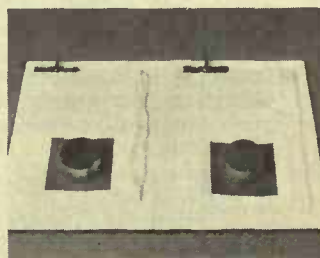
## Proof Positive That Quilted Pampers Stay Twice as Dry as Cloth



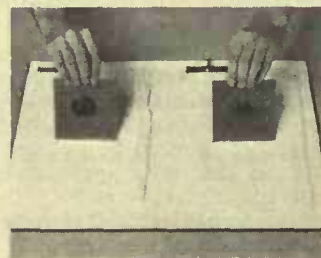
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water are placed on  
each diaper



A blotter is placed  
over each wetted  
area



A weight is placed on  
each blotter



Quilted Pampers is  
twice as dry as cloth



# Quilted Pampers— as dry as cloth

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# names & faces

**Dr. Amy Zelmer**, currently dean of the University of Alberta's Faculty of Nursing, has been appointed associate vice-president (academic) of the university, effective July 1, 1980. A graduate of the Ottawa Civic Hospital School of Nursing, Dalhousie University, the University of Michigan and Michigan State University, she has worked in public health in Nova Scotia and Alberta. In 1975, Dr. Zelmer worked with the World Health Organization as a health education specialist in India, where she and her colleagues were responsible for providing support services for educational activities in ten Asian countries.

**Marjorie W. Hayes, RN, BScN, MScN**, has been appointed Director of the Health Computer Information Bureau. Most recently, she was Project Director of the bilingual, multi-media home health care program "There's

No Place Like Home For Health Care", which was sponsored by St. John Ambulance and the Canadian Red Cross Society. HCIB represents the first attempt ever to establish a central clearing house for comprehensive information about computer uses and users in the health field.

**Barbara A. Racine** has been appointed Administrator of the In-Patient Division and Director of Nursing of the Alberta Children's Hospital in Calgary. A graduate of the Master of Health Services Administration program of the University of Alberta, she was Assistant Administrator of Nursing Services at Saint John's Hospital, Santa Monica, California, has held senior nursing and administrative positions in Canada and the U.S.A., and has served as Assistant Professor at the University of Alberta.

**Carolyn S. Roberts**, a Canadian scholar is the first recipient of the Patricia Christensen Memorial Scholarship Award. The award and fund was established by friends of the late Patricia Christensen, a Canadian nursing scholar and former chairman of the maternity nursing department, Texas Christian University.

Roberts who is currently working on her Ph.D. at Wayne State University, Detroit is associate professor of the University of Western Ontario and a former teacher at Belleville General Hospital, Belleville, Ontario and St. Mary's School of Nursing, Sault Ste. Marie, Ontario.

Roberts received her basic education at The Royal Victoria Hospital, Montreal, a B.Sc.N. at the University of Western Ontario and a Master's degree at Teacher's College, Columbia University. She has received a number of awards and scholarships and is an active member of many professional organizations.

**Shirley L. Brandt** has been appointed director of continuing education in nursing at the School of Nursing, University of British Columbia, Vancouver effective August 1, 1979. She has held a number of positions in nursing education and service and has also served as director of continuing education in nursing particularly in developing programs in the areas of infection control, emergency care and primary care.

Brandt is a graduate of the Lenox Hill Hospital School of Nursing in New York. She also holds a B.A. and M.A. in education.

**Margaret S. Neylan, RN, BScN, MA**, was admitted as a Servicing Sister of the Most Venerable Order of the Hospital of St. John of Jerusalem by Governor General Edward Schreyer, in a ceremony at Notre Dame Basilica in Ottawa. Her investiture recognized her

commitment and outstanding efforts in the community, particularly as head of the Nursing Advisory Committee for St. John Ambulance in British Columbia for several years. Currently, she is involved with a Red Cross project on health in the home, as well as her full time position with the British Columbia Institute of Technology as Head of the Psychiatric Nursing Department.

**Rachel Bard, BScN**, a community health nurse in Moncton, N.B., has been awarded the Marjorie Hiscott Keyes Medal for 1979 by the Canadian Health Association. The medal, named for one of the pioneers of the Canadian mental health movement, is awarded annually to the nurse who most nearly approaches the ideal of psychiatric nursing through demonstration of interest, understanding and warmth of personality in daily contact with the mentally ill. A graduate of the Ecole des Sciences Infirmières in Edmunston, N.B. and the University of Moncton, Bard is the senior mental health nurse and acting coordinator of the child psychiatry team at the mental health clinic in Moncton, N.B.

**Una Ridley**, formerly principal of the Brockville Campus of St. Lawrence College, has been appointed professor of nursing and dean of the College of Nursing at the University of Saskatchewan. A past president of the Council of the College of Nurses in Ontario, she has done much research in the area of nursing education.

**Dr. Joanne Scholdra**, previously chairman of the Lethbridge Community College nursing program, has been appointed director of the newly established University of Lethbridge School of Nursing. Dr. Scholdra has an extensive background in general duty nursing, administration and education. ♡

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# audiovisual

**Medications.** A series of five self-instructional slide tape programs written by Rhoda Bowen and Joy Schermer of Wayne State University. Produced by Media Systems Corporation, a Subsidiary of Harcourt, Brace and Janovich, Inc., 757 Third Avenue, New York, NY 10017. Average length: 20 minutes.

Cost: \$150.00 per program.

A newcomer to the health field, Media Systems Corporation has produced several slide/tape programs on nursing fundamentals. The quality of their programs reflects many years of experience producing self-instructional audiovisual materials for business education.

In 1977 a series of five programs on medications was released. The three most useful are described here.

**Math for Medications:** relates math to the preparation of medications in tablet or injectable form. It clearly differentiates between generic and trade names, available and prescribed dose and carefully reviews what medication orders and labels tell us. Metric, apothecary and household systems of measurement, with a table of approximate equivalents, are given. Many practice exercises are included.

**Administering Oral Medications:** safety and the "5 rights" are emphasized. Reviews both the unit dose and traditional systems of preparation and refers briefly to various agency procedures related to drug and narcotic control. Gives common abbreviations and demonstrates the preparation and administration of both tablet and liquid medications. What to record and how to handle problems which may arise, such as, dubious order, client not being in his/her room, or client refusing the medication, are included.

**Administering Injections:** tells how and why intradermal, subcutaneous and

intramuscular injections are given, including syringe and needle sizes. Excellent graphic slides demonstrate tissue involved, anatomy, sites and injection angles. The four intramuscular injection sites are well demonstrated with most emphasis on dorsogluteal and ventrogluteal sites. Ways of locating all sites are clearly visualized.

The remaining two programs in the series cover topical medications and preparing for injections.

A word about packaging: carousel slide trays are used and come in attractive, sturdy boxes with snug foam inserts for audiocassettes. Slides are plastic mounted with slide number and program name on the mounting for easy identification.

These are exceptional programs for nursing students and registered nurse refresher courses.

*Reviewed by Joyce Carver, BN, M.Ed., Lecturer, Dalhousie University School of Nursing, Halifax, Nova Scotia.*

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Spectrex announces the availability of over 250 new programs in nursing. The programs cover such varied subjects as the nursing process, nursing procedures, care of the diabetic patient, nursing care in pediatrics and geriatrics, as well as 33 additional programs for nurses' aides.

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For information, write: Spectrex Limited, 701 Evans Ave., Toronto, Ontario M9C 1A3.

**Alcohol and Your Patient,** by Madelaine Coates, RN and Gail Paech, RN, MScN, Toronto, Addiction Research Foundation, 1979.

Approximate price: \$1.95.

In the introduction to this handbook, the nurse is described as "the ideal person to identify the existence of an alcohol problem which may make diagnosis difficult and/or treatment unsatisfactory." Bearing the nurse's special position in mind, this handbook is written to give the nurse a good general understanding of alcohol as a chemical substance, how it affects people both physically and psychologically, and what nurses can do to accurately assess an alcoholic's problem and design a 'blueprint for action'.

The authors accomplish this by delivering a great deal of information in a very concise form: information is presented in "point form", for example, and diagrams are used to advantage. Topics include the effects of alcoholism on family structure, alcohol and women, and up-to-date information on the fetal alcohol syndrome. Of interest as well is a list of helping agencies for the nurse's use in referring her patients.

Acknowledged is the help of the RNAO in the production of the handbook.

For more information, contact the Addiction Research Foundation, 33 Russell Street, Toronto. ☛

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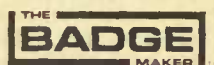
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# research

## • Families

**Familial Strain and the Development of Normal and Handicapped Children in Single and Two Parent families.** Toronto, Ont., 1979. Thesis (PhD), University of Toronto by *Sharon Ogden Burke*.

The relationship of chronic familial strain and developmental quotients in children was studied in one and two parent families with and without handicapped children. Sixty families were studied, each having at least one of the stressors of a handicapped child or a single parent or both stressors.

High chronic familial strain was significantly related to low developmental quotients in normal children. Families with high chronic strain levels were characterized by a lack of short and long term plans and strategies for dealing with day-to-day changes. They were highly concerned with the immediate family unit and unaware of community and other outside influences. Both the presence of a handicapped child and a single parent were associated with lower developmental quotients in normal children. Maternal strain is related to, but conceptually distinct, from chronic familial strain. High maternal strain was related to higher developmental quotients in handicapped children and at the same time low developmental quotients in the normal siblings.

## • Gerontology

**Problems of the Independent Elderly in Using the Telephone to Seek Health Care.** Toronto, Ont., 1979. Thesis (MScN), University of Toronto by *Heather Caloren*.

This exploratory-descriptive study involved interviewing 72 persons sixty-five years of age or older who spoke English and who lived alone in the city of Toronto, to determine problems experienced using the telephone to contact health care services.

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Results revealed that an important number of independent elderly persons experience problems using the telephone to contact services and there is a small number who fail to contact services when they have perceived needs. The organization of health care services on the premise that those in need will phone for them should be reappraised. Those who experience contact problems tend to neglect chronic and less acute problems. Groups such as the visually impaired and those who began telephone use late in life may experience a greater number of contact problems than others and men may display more reticence than women about using the telephone. Telephone recording devices are a source of concern or difficulty for some independent elderly persons.

By recognizing these findings, health care providers in planning access for service should adjust their practices to minimize these problems.

## • Nursing Education

**The Use of Written Simulations to Measure Problem Solving Skills of Nursing Students.** Ann Arbor, Michigan, 1979. Thesis (PhD), University of Michigan by *Margaret Findlay Munro*.

This study was a pilot project in the development and use of three written simulations of community health nursing to measure problem solving skills. A convenience sample of 47 baccalaureate students in nursing was randomly assigned to three test groups which received the three simulations in a fixed order at approximately weekly intervals. Concurrent data were gathered from evaluation rating reports indicating the problem solving behavior of the students and the primary medical and/or nursing problems encountered with clinical practice.

The study suggests that individual problem solving competency and style can be measured by means of written simulations. Opportunities for decision-making, errors and consequent progress were valid and reliable within instrument and sample. Further use of these and sequential problem situations is recommended to test and teach problem solving.

## • Retirement

**Self-actualization in Retirement.** Naples, Florida, 1978. Thesis (PhD), Walden University by *Rebecca P. Kingston*.

This was an empirical study of the self-actualization of the coping, older person, retired from the labor force and living among a general urban population. The findings revealed that the overall level of self-actualization of the retired person was low-average, with the group having only primary school education scoring lowest on most scales. Satisfaction with environmental variables in retirement was positively correlated with self-actualization and satisfaction with one's financial situation was shown to be the most influential environmental variable on self-actualization in retirement.

## • Congenital Anomalies

**Assimilative and Accommodative Responses of Mothers to Their Newborn Infants With Congenital Defects.** Pittsburg, Pennsylvania, 1979. Thesis (PhD), University of Pittsburg by *June Kikuchi*.

To determine the responses of mothers to newborn infants who have congenital defects which require hospitalization in a children's hospital immediately following birth, five mothers whose newborn babies were hospitalized within two to eighteen hours after birth were studied individually using unstructured interviews.

Results showed the mothers to be reality oriented and anxious to determine what kind of infants they had produced and had to mother. It appeared to take these mothers longer than a month to become fully acquainted with their infants. During the initial few contacts with their infants, it seemed to be especially important for the mothers to have successful feeding experiences and to see their infants awake and active. Opportunities to prepare themselves through the expression of both fearful and wishful fantasies about their infants was extremely important as was the freedom to optimize and to protest about their infants' condition.

## • Cardiac Surgery

**Knowledge of Prescribed Medical Regime, Concerns and Unanswered Questions Reported by Wives of Aortocoronary Bypass Patients in Early Convalescence.** Toronto, Ont. 1979. Thesis (MScN), University of Toronto by *Joseline M. Sikorski*.

The purpose of this study was to determine the knowledge, concerns and unanswered questions of wives of aortocoronary bypass patients in early convalescence and ultimately to determine information specific to the home environment and early convalescence that would assist wives to support their husbands during this period.

A convenience sample of 30 wives of aortocoronary bypass patients was interviewed privately in their own homes the second or third week after their husbands' discharge from hospital.

The majority of wives had excellent knowledge of coronary risk factors, physical discomforts and recommended activities; they lacked adequate information on medications, diet, weight, knowledge of the surgery and its relationship to coronary artery disease and angina, sexual activity resumption and general activity levels.

The study concluded that multi-disciplinary preoperative, postoperative and convalescent information and support for the spouse and patient should be improved and early convalescent community nursing visits for reinforcement and support are needed.

*Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.* ♡



## June 1980 51



# books

**Case studies in neurological nursing**  
by S. Wehrmaker and J.  
Wintermeute. Boston, Little, Brown  
& Co., 1978.  
*Approximate price: \$7.95.*

The major purpose of this collection of case studies is to provide nurses with a "framework of practical knowledge in the neurological sciences". This purpose is achieved by beginning the book with a

review section, clearly and concisely written, on neuroanatomy and physiology and in the presentation of case studies.

The emphasis is squarely on the nurse's role in the care of patients with neurological disorders. Items of interest such as the screening evaluation of motor strength which can be done routinely by a nurse, cranial reviews emphasizing those tested frequently by nurses, bring to mind things that most nurses do without realizing that they're also evaluating neurological function. Each chapter ends with short multiple choice quizzes so that the nurse-reader may evaluate her/his knowledge gained

and the ability to apply that knowledge.

Each of the case studies follows a question and answer format for the particular disorder being discussed. The information given in response to each question follows loosely the ideas of the Nursing Process, i.e. information needed for assessment of the patient and care planning, to various types of testing methods, to the nursing management of that patient.

Nurses who would benefit from reading this book would be those working on a neurological service, or in an outpatient neurology clinic. Others for whom certain conditions would be relevant would be those working on a general medical unit, where patients with transient ischaemic attacks, or cerebrovascular accidents are normally admitted.

*Reviewed by Phyllis Durnford, Teaching Master, Algonquin College Nursing Program, Pembroke, Ontario.*

**Pediatric cancer therapy** by Carl Pochedly, ed. 292 pages. Baltimore, University Park Press, 1979.  
*Approximate price: \$29.50.*

This book presents current concepts and technology in the treatment of the various malignancies of childhood. It includes the following: new diagnostic techniques; detailed descriptions of various recommended therapy regimens (new drugs, new approaches); management of infection in children with cancer; supportive care; a sensitive chapter on emotional care considerations for the patient and his family; improved prognostic data.

The book is a collaborative effort by American authors who are experts in their fields. It has been edited by one and is meant to be a reference for pediatricians and general practitioners who assist in the care of pediatric cancer patients. It is directed with the expressed hope that these practitioners may assume a more meaningful role on the cancer management team.

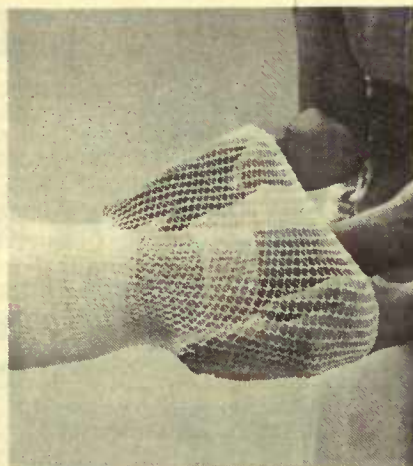
The content is current; the book is easy to read. Graphs and diagrams are used appropriately and are easy to understand. Photographic reproductions of x-rays are used extensively and effectively. Much less effective are black and white photographs of living tissues, tissue specimens and microscopic slides, where color plates would have provided much more visual information.

In short, this book is a worthwhile reference for those to whom it is directed and for nurses who are associated with care of pediatric cancer patients and their families.

*Reviewed by June L. Blau, RN, Nursing Inservice Instructor, Pediatrics, Regina General Hospital, Regina, Sask.*

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**The Nursing Process - a Scientific  
Approach to Nursing Care** by Ann  
Marriner. 276 pages. Saint Louis,  
Mosby, 1979.

*Approximate price: \$12.00*

This book is a compilation of selected readings on various concepts related to the four phases of nursing process. Some of the concepts discussed include problem oriented medical records, nursing diagnosis and communication and quality nursing care.

The book is divided into four sections: the first presents an overview of nursing process and subsequent sections deal with the assessment, planning, implementation and evaluation phases. The methods, skills and strategies for implementing each phase are discussed in depth and case studies are used in some of the readings to effectively exemplify the proper use of nursing process in enhancing nursing care. The holistic approach used in this book — that is, looking at the whole before the individual phases of process — makes the readings more meaningful, and the comprehensive annotated bibliography at the end of each chapter supplements the content.

*Reviewed by Shirley Wong, Assistant  
Professor, School of Nursing, Dalhousie  
University, Halifax, N.S.*

**Basic Concepts in Anatomy and  
Physiology, A Programmed  
Presentation** by Catherine P.  
Anthony and Gary A. Thibodeau,  
Toronto, Mosby, 1980.  
*Approximate price: \$10.75.*

This book is difficult to compare with other texts of the same topic because of the way in which the material is presented. Certainly the book is unique because it is a programmed presentation, which might be an interesting way in which to present Anatomy and Physiology to students.

However, as a "basic" book of Anatomy and Physiology, the concepts as presented in the content material of the book would be difficult for basic students studying Anatomy and Physiology to grasp. They most certainly would require a guide, whether it be another text, a manual, or an instructor, to explain the format and terms. Certainly, the illustrations and the panels of information are a great help; these items may be the best features to the student reading this book.

Strangely enough, two of the most important body systems have been omitted "to keep the cost of the book reasonable" — muscular and skeletal systems. The digestive system has also been omitted from the contents. Because of these omissions, the book appears to be incomplete as a text for Anatomy and Physiology.

On the other hand, the book has an extremely good feature in that it can be used as a study guide or review for students who have already studied Anatomy and Physiology; the programmed presentation makes this possible.

So, the book would be a good one to recommend to students or other persons who already have some Anatomy and Physiology background, such as in Nursing, Medicine or Physical Education. I find this book to be a good way of reviewing my understanding and retention of the main concepts in those areas of Anatomy and Physiology covered in the book, but because it is difficult to find needed information quickly, I would prefer to use another type of Anatomy and Physiology text. Therefore, I would hesitate to purchase, or recommend that someone purchase it, unless it was used mainly as a study guide or a review book.

*Reviewed by Katharina A. Burns, PhD,  
MD, Assistant Professor, School of  
Nursing, Memorial University of  
Newfoundland, St. John's, Nfld.*



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**Nurses' handbook of fluid balance** 3d ed., by N. Metheny and W.D. Snively, Toronto, Lippincott, 1979.

I was initially introduced to this book as a new graduate, when the first edition was published in 1967. Now, as then, I welcomed the straightforward approach of the authors to the complex subject of body fluid disturbances.

The third edition retains the basic format of dividing the text into chapters on the "fundamentals" of body fluids and the related imbalances and also chapters relating the knowledge to practical application.

Although the authors have done a thorough revision and expansion of the original text, and have added considerable material related to increased knowledge and developing technology, one of the major strengths is the continuing focus on the nurse and her role. Several current "nurse's handbooks", and "programmed learning" texts are, in my opinion, lacking in this important area.

In summary, I would recommend this book as an excellent handbook for hospital and nursing unit libraries, for individual graduate nurses, and certainly recommend it highly as a reference for students in hospital, college or university nursing programs.

*Reviewed by Dawn Patterson, RN, B.Sc., Instructor, Nursing Department, Cariboo College, Kamloops, B.C.*

**Introductory maternity nursing** by Doris C. Bethea, Toronto, Lippincott, 1979.

Doris C. Bethea has not succeeded in her book in presenting the unique and valuable contribution that today's nurses make towards care of the new mother, her infant and their significant other.

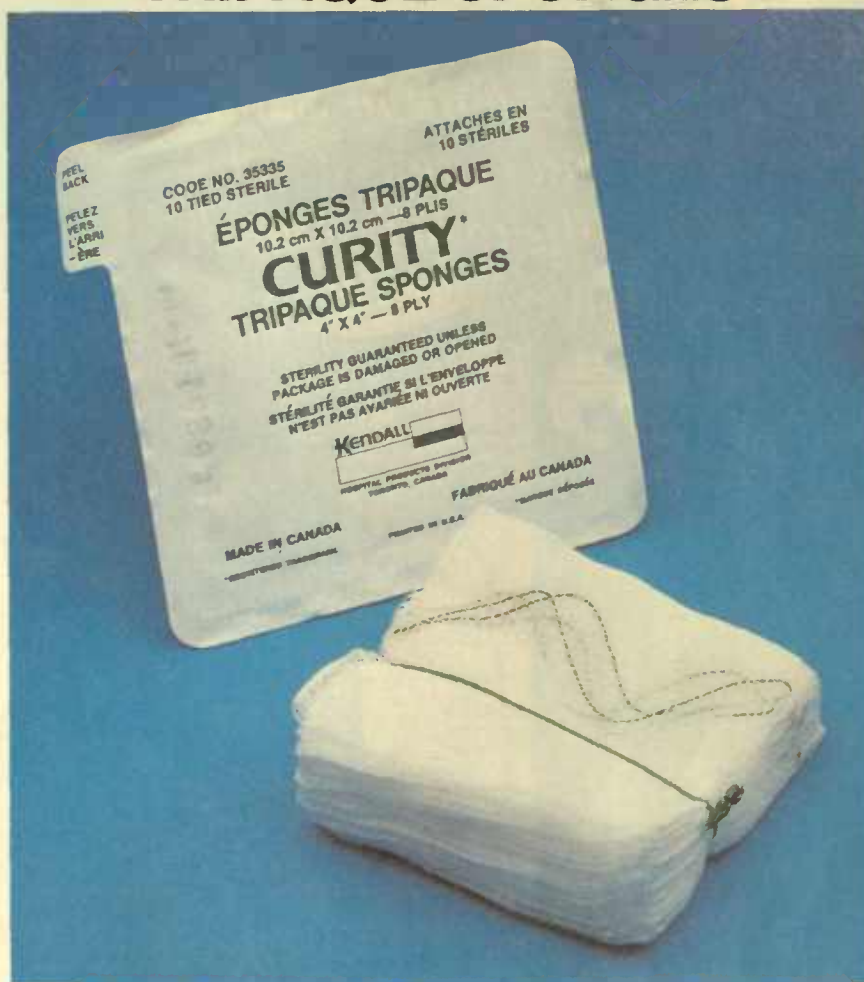
Rather than presenting a progressive nursing perspective on the care of the childbearing family, the author has taken a predominantly medical orientation.

The author introduces each chapter with a list of behavioral objectives and presents material which enables the reader to meet these objectives; however, the content is not always complete and up-to-date. Some important topics such as how to assist the mother to breastfeed successfully are dealt with quite inadequately. In other cases, the information given is not current, for example the use of general anesthetics in delivery or the recommended weight gain during pregnancy.

*Reviewed by Antoinette LeBlanc, BScN., Instructor, The Miss A. J. MacMaster School of Nursing, Moncton, N.B.*

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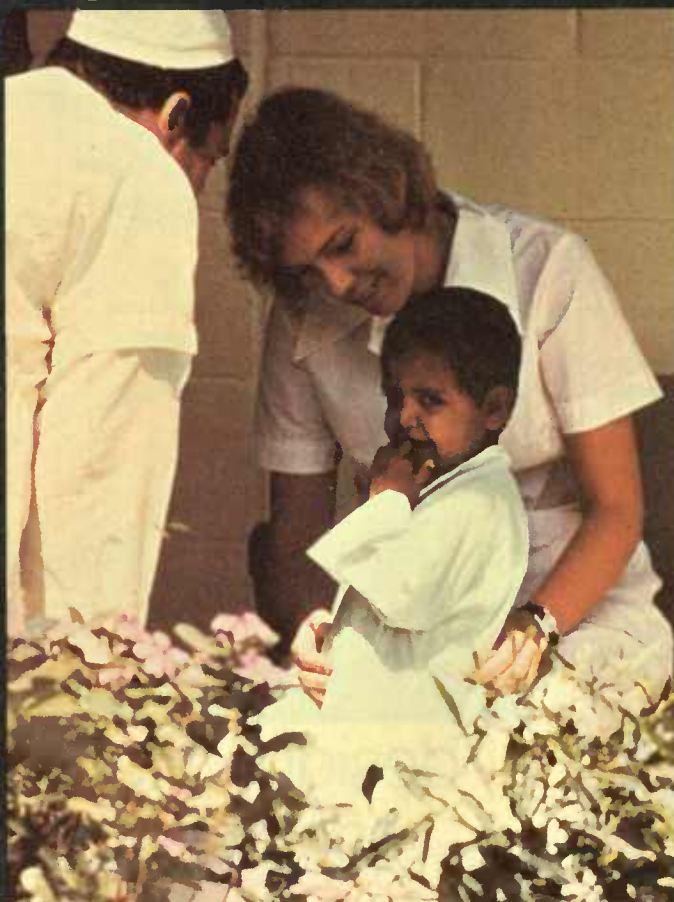
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Registered Nurses required for a 560-bed acute care hospital in Edmonton, Alberta. Positions available in most clinical areas. Candidates must be eligible for registration in Alberta. Current salary rates under review. Apply to: Personnel Department, Edmonton General Hospital, 1111 Jasper Avenue, Edmonton, Alberta T5K 0L4.

Registered Nurses. We invite you to join our Health Care Team at the Fort McMurray Regional Hospital which is expanding from a 75-bed hospital to a 300-bed hospital. We will provide you with a challenging professional opportunity as a primary nurse involved in our high level patient care programs. Good employee benefits, salary as per the Collective Agreement and registration as per the A.A.R.N. Please contact: Human Resources, Fort McMurray Regional Hospital, 7 Hospital Street, Fort McMurray, Alberta T9H 1P2, (403) 743-3381, ext. 19.

Registered Nurses required for 75-bed, accredited, active treatment hospital (including I.C.U.). Situated in a lakeland resort area, 130 miles northeast of Edmonton. Salary according to AARN contract. Apply to: Director of Nursing, St. Therese Hospital, Box 880, St. Paul, Alberta T0A 3A0.

Required—Full-time and part-time Registered Nurses to rotate all three shifts in Active Treatment 66-bed hospital. Apply to: Director of Nursing, Taber General Hospital, Box 939, Taber, Alberta T0K 2G0.

## British Columbia

Experienced General Duty Graduate Nurses required for small hospital located N.E. Vancouver Island. Maternity experience preferred. Personnel policies according to RNABC contract. Residence accommodation available \$30 monthly. Apply in writing to: Director of Nursing, St. George's Hospital, Box 223, Alert Bay, British Columbia V0N 1A0.

General Duty Nurse for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurse's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia V0H 1H0.

Two Registered Nurses required for a 21-bed general hospital located in the beautiful Robson Valley, 100 miles West of Jasper, Alberta. Rotating shifts, full or part-time work available. Accommodation available for single person. Salary as per RNABC Collective Agreement. Apply immediately to: Director of Nursing, McBride & District Hospital, Box 128, McBride, British Columbia V0J 2E0 or telephone: 604-569-2662.

## British Columbia

General duty nurses required for all clinical areas and O.R. in a 360-bed acute care general hospital. Salary and fringe benefits in accordance with RNABC contract terms. Apply to: The Director of Nursing, Nanaimo Regional General Hospital, Nanaimo, B.C. V9S 2B7.

General Duty R.N.—Small hospital in scenic West Kootenays of B.C. Apply: Slokan Community Hospital, Box 129, New Denver, British Columbia V0G 1S0.

Experienced Nurses (B.C. Registered) required for a newly expanded 463-bed acute, teaching, regional referral hospital located in the Fraser Valley, 20 minutes by freeway from Vancouver, and within easy access of various recreational facilities. Excellent orientation and continuing education programmes. Salary—1979 rates—\$1305.00-\$1542.00 per month. Clinical areas include: Operating Room, Recovery Room, Intensive Care, Coronary Care, Neonatal Intensive Care, Hemodialysis, Acute Medicine, Surgery, Pediatrics, Rehabilitation and Emergency. Apply to: Employment Manager, Royal Columbian Hospital, 330 E. Columbia St., New Westminster, British Columbia V3L 3W7.

Experienced Nurses (eligible for B.C. Registration) required for full-time positions in our modern 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC Contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia V3L 5E8.

Experienced General Duty Nurses required for 130-bed accredited hospital. Salary in accordance with RNABC Contract. Residence accommodation available. Apply in writing to: Director of Nursing, Powell River General Hospital, 5871 Arbutus Avenue, Powell River, British Columbia V8A 4S3.

Registered Nurses required for permanent full-time position at a 147-bed fully accredited regional acute care hospital in B.C. Salary at 1979 RNABC rate plus northern living allowance. One year experience preferred. Apply: Director of Nursing, Prince Rupert Regional Hospital, 1305 Summit Avenue, Prince Rupert, British Columbia V8J 2A6. Telephone (collect) 604-624-2171 Local 227.

Experienced General Duty Nurses, preferably eligible for B.C. Registration, required for 71-bed accredited hospital on the Sunshine Coast of British Columbia. Salaries and benefits according to RNABC agreement. Residence accommodation available. Apply in writing to: Personnel Officer, St. Mary's Hospital, Box 7777, Sechelt, B.C. V0N 3A0.

Registered Nurses required immediately for permanent full time positions at 10-bed hospital in B.C. Salary at 1978 RNABC rate plus northern living allowance. Recognition of advanced or primary care education. One year experience preferred. Apply: Director of Nursing, Stewart General Hospital, Box 8, Stewart, British Columbia V0T 1W0. Telephone: (604) 636-2221 Collect.

General Duty Nurses required for an active, 103-bed hospital. Positions available for experienced R.N.'s and recent Graduates in a variety of areas. RNABC Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

## Manitoba

Registered nurses required for a fully accredited 100-bed general hospital and a 72-bed personal care home located in northern Manitoba. Must be eligible for registration in Manitoba. Salary dependent on experience and education. For further information contact: Mrs. Mona Seguin, Personnel Director, St. Anthony's General Hospital, The Pas Health Complex Inc., P.O. Box 240, The Pas, Manitoba R9A 1K4; or phone collect to: 1-204-623-6431, Ext. 179.

## Northwest Territories

The Stanton Yellowknife Hospital, a 72-bed accredited, acute care hospital requires registered nurses to work in medical, surgical, pediatric, obstetrical or operating room areas. Excellent orientation and inservice education. Some furnished accommodation available. Apply: Assistant Administrator-Nursing, Stanton Yellowknife Hospital, Box 10, Yellowknife, N.W.T., X1A 2N1.

## Ontario

Registered Nurses required for our ultra modern 70-bed fully accredited general hospital in a bilingual community of Northern Ontario. Applicants should be registered or eligible for registration with the College of Nurses of Ontario. Knowledge of both official languages and experience in nursing are assets but not essential. Salary is according to the O.M.A. schedule and fringe benefits include one month of holidays, OHIP, salary and life insurance and a drug and dental plan. Assistance is also provided in locating suitable living accommodations. Forward your application to: Personnel Director, Notre Dame Hospital, P.O. Box 8000, Hearst, Ontario P0L 1N0. Telephone: (705) 362-4291.

Registered Nurses for a 150-bed fully accredited general hospital. Salaries in accordance with association agreement. Apply to: Mr. C.F. Dowling, Personnel Department, Lake of the Woods District Hospital, 21 Sylvan Street West, Kenora, Ontario P9N 3W7. Phone: 807-468-9861.

Experienced registered nurses are required immediately for our fully accredited thirty-two bed complex and active treatment hospital located in beautiful Northern Ontario. The hospital pays 100 percent OHIP and Dental Plan and many other excellent fringe benefits. Apply to: The Director of Nursing, Hornepayne Community Hospital, Hornepayne, Ontario P0M 1Z0.

Looking For A Temporary Change? Do you want to keep your job but feel the need for some renewing experience? International registry for nurses interested in a temporary job exchange under organization. Write: Nursing Job Exchange, Box 1502, Kingston, Ontario K7L 5C7.

R.N. Grad or R.N.A., 5'6" or over and strong, without dependents. Non-smoker for 180 lb. handicapped retired executive with stroke. Able to transfer patient to wheelchair. Live-in 1/2 year in Toronto, 1/2 year in Miami. Wages \$250.00 to \$300.00 weekly NET plus \$100.00 weekly bonus on most weeks in Miami. Write: M.D.C., 3532 Eglinton Avenue West, Toronto, Ontario M6M 1V6.



## Ontario

Children's summer camps in scenic areas of Northern Ontario require Camp Nurses for July and August. Each has resident M.D. Contact: Harold B. Nashman, Camp Services Co-op, 825 Eglinton Avenue West, Suite 211, Toronto, Ontario M5N 1E7. Phone: (416) 789-2181.

## United States

**California**—Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, Ext. 1680.

Total patient care with all licensed personnel is our goal! Staff RNs currently interviewing for part-time and full-time positions. Full service, except psych, progressive 156-bed accredited acute general hospital. Located within 60 minutes from L.A., the ocean, mtns., and the desert. Orientation and staff development programs. CEUs provider number. Parkview Community Hospital, 3865 Jackson Street, Riverside, California 92503. Write or call collect 714-688-2211 Ext. 217. Betty Van Aernam, Director of Nursing.

**Fort Lauderdale Beach** an extra benefit enjoyed by Nurses employed at Holy Cross Hospital. Our 596-bed health care complex will sponsor Work Visas for qualified R.N.'s and new Graduates interested in a challenging professional opportunity. For details regarding licensure, relocation and hospital-owned apartment rentals, contact our Nurse Recruiter, 800 N.W. 62nd St., Suite 510, Ft. Lauderdale, Florida 33309 (305) 772-3680.

**Appraise our Miami Hospital** — What can Victoria Hospital offer you? We can give you a modern 300-bed progressive, acute care hospital as a stimulating work environment. We offer excellent salaries, benefits, CEU's, tuition refunds and relocation assistance. For pleasure, Miami has great beaches, boating, dining, discos, tennis, golf, snorkeling, etc. Our Hospital also has apartments available. Want to learn more? Call Ms. McDonald, R.N., person-to-person, collect at (305) 772-3682, or write Nurse Recruiter, 800 N.W. 62nd St., Suite 510, Ft. Lauderdale, Fla. 33309.

**Nurses—RN's—Immediate openings in California-Florida-Texas-Maryland-Virginia and many other States**—if you are experienced or a recent Graduate Nurse we can offer you positions with excellent salaries up to \$16,000 per year plus all benefits. Not only are there no fees to you whatsoever for placing you, but we also provide complete Visa and Licensure assistance at also no cost to you. Write immediately for our application even if there are other areas of the U.S. that you are interested in. We will call you upon receipt of your application in order to arrange for hospital interviews. You can call us collect if you are an RN who is licensed by examination in Canada or a recent graduate from any Canadian School of Nursing. Windsor Nurse Placement Service, P. O. Box 1133, Great Neck, New York 11023 (516) 487-2818.

"Our 23rd Year of World Wide Service"

**R.N.s—Experienced nurses needed to staff midwestern and eastern United States hospitals.** Must be able to take and pass State boards tests. Free housing while working in United States. Full sponsorship available. Wages begin at \$7.00 per hour. Fulltime. Send resume to: Bonnie Menees Smith, R.N. Recruiter, JANNA Medical Systems, Inc., 1810 Craig Road, St. Louis, Missouri 63141.

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A 326 bed, J.C.A.H. accredited hospital offering attractive salaries and benefits including:

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We will sponsor the appropriate employment Visa for qualified applicants. Attractive efficiency apartments available at far below commercial rates, overlooking the beautiful Lake Worth and located across the boulevard from the hospital.

Write:

Director of Personnel (305) 655-5511  
Good Samaritan Hospital  
Flagler Drive at Palm Beach Lakes Blvd.  
P.O. Box 3166  
West Palm Beach, Fla. 33402

## United States

**The Best Location in the Nation** — The world-renowned Cleveland Clinic Hospital is a progressive, 1030-bed acute care teaching facility committed to excellence in patient care. *Staff Nurse positions* are currently available in several of our ICU's and 30 departmentalized medical/surgical and specialty divisions. Starting salary range is \$14,789 to \$17,056, plus \$1248/year ICU differential and premium shift differential, comprehensive employee benefits and an individualized 7 week orientation. We will sponsor the appropriate employment visa for qualified applicants. For further information contact: Director-Nurse Recruitment, The Cleveland Clinic Hospital, 9500 Euclid Avenue, Cleveland, Ohio 44106 (4 hours drive from Buffalo, N.Y.); or call collect 216-444-5865.

**Nurses—RN's—Suite yourselves professionally, personally, financially and geographically.** I have clients throughout the U.S. needing nurses. We provide full visa and licensure assistance. No charges to you. Contact: Jack Grinovich & Assoc., 7300 NW 23rd St., Bethany, Oklahoma 73008 (405) 789-4563.

**Come to Texas—Baptist Hospital of Southeast Texas** is a 400-bed growth oriented organization looking for a few good R.N.'s. We feel that we can offer you the challenge and opportunity to develop and continue your professional growth. We are located in Beaumont, a city of 150,000 with a small town atmosphere but the convenience of the large city. We're 30 minutes from the Gulf of Mexico and surrounded by beautiful trees and inland lakes. Baptist Hospital has a progress salary plan plus a liberal fringe package. We will provide your immigration paperwork cost plus airfare to relocate. For additional information, contact: Personnel Administration, Baptist Hospital of Southeast Texas, Inc., P.O. Drawer 1591, Beaumont, Texas 77704. An affirmative action employer.

**RN'S—Our Florida hospitals need you!** Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. No Fees! Call or write: Medical Recruiters of America, 3421 West Cypress St., Tampa, Florida 33607 (813) 872-0202.



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Now A.M.I. is Recruiting R.N.'s for Hospitals in Texas. Immediate Openings. Salary Range \$11,000 to \$16,500 per Year.

You can enjoy nursing in General Medicine, Surgery, ICC, CCU, Pediatrics and Obstetrics

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Without obligation, please send me more Information and an Application Form.

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CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE ( ) \_\_\_\_\_  
LICENSES: \_\_\_\_\_  
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**Before accepting any position in the U.S.A. PLEASE CALL US COLLECT**

**We Can Offer You:**

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Immediate openings for qualified RN's on all shifts, full time, part time. 203 bed JCAH accredited acute care hospital, adjacent to Oregon Institute of Technology, offering a 2 + 2 AD/BSN program. We are located in Southern Oregon. Excellent year 'round outdoor activities. Family oriented community. Excellent working conditions and benefits. Competitive salary with opportunity for advancement. Contact Personnel Department, MERLE WEST MEDICAL CENTER, 2865 Daggett St., Klamath Falls, OR 97601, or call COLLECT (503) 882-6311, Ext. 131. We are an equal opportunity employer.

## United States

Nurses—RN's—A choice of locations with emphasis on the Sunbelt. You must be licensed by examination in Canada. We prepare Visa forms and provide assistance with licensure at no cost to you. Write for a free job market survey Or call collect (713) 789-1550. Marilyn Blaker, Medex, 5805 Richmond, Houston, Texas 77057. All fees employer paid.

## Miscellaneous

Electrolysis — Successful Electrolysis Practice for Sale. 6 months specialized included. Write or phone: Margot Rivard, 1396 St. Catherine Street West, Suite 221, Montreal, Quebec, H3G 1P9. Telephone: (514) 861-1952.

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## R.N.'s

### Come to Texas

- 244 Bed Regional Medical Center
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- Progressive Nursing Administration
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- Excellent salary and benefits program
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### Contact:

Bonita Palmer, R.N.  
Director of Nursing  
Texoma Medical Center  
P.O. Box 890  
Denison, Texas, USA 75020

# Choose a Nursing Career in Canada's Ocean Playground



The Victoria General Hospital, Halifax, Nova Scotia is the Maritime's largest teaching hospital. Close association with Dalhousie University and our own extensive continuing education program provide excellent opportunities for learning and career development.

The Victoria General Hospital offers a variety of nursing specialties for experienced people looking for a professional environment and challenge. Victoria General Nurses have full civil service benefits.

- **GENERAL DUTY NURSES** work in our 28 general nursing units, each of which have specific sub-specialties in Medicine and Surgery.
- **INTENSIVE CARE NURSES** are part of five specialized units such as Coronary, Cardiovascular, Medical, Surgical and Neurosurgery.
- **SPECIALTY AREA NURSES** work in the Burn Unit, Renal Unit, Emergency, Operating Room, Recovery Room or Out-Patients.
- **NURSING ADMINISTRATION.** We encourage promotion through an on-going program of leadership development.

Please quote Competition Number: 80-310.

For details on nursing opportunities contact:

Mrs. Betty Elliot, R.N.

Personnel Department, Victoria General Hospital

578B University Avenue

Halifax, Nova Scotia B3H 1V8

Telephone: 1 (902) 428-3484



## The Registered Nurses Association of Nova Scotia invites applications for Nursing Consultant—Education

### Duties:

To provide assistance and consultation to schools of nursing, as well as the organization and development of continuing education programs for nurses.

To act as resource person to committees of the Association.

To act as liaison with government, health care and educational institutions and other associations.

### Qualifications

Applicant must be eligible for registration in Nova Scotia. Preparation in education at the Master's level preferred, with at least ten years experience in nursing and nursing education.

Salary negotiable.

### Position Available August 1, 1980

Applications with complete resumé of qualifications, experience and the names of three references should be submitted to:

Executive Secretary  
Registered Nurses Association  
of Nova Scotia  
6035 Coburg Road  
Halifax, Nova Scotia  
B3H 1Y8

## Registered Nurses

Planning your summer vacation?

Then by all means, include a visit to beautiful Vancouver in your plans. And while you're here, drop in and discuss your nursing career opportunities at **Shaughnessy Hospital**, an 1100 bed multi-level community teaching hospital.

We have full-time, part-time and float positions available as well as a 2 week orientation for RN's who wish to work on a casual basis only.

When you're in Vancouver please call:

Jane Mann  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C.  
V6H 3N1  
(604) 876-6767



## R.N.'s Required

Applications are invited for full time nurses to work rotating shifts in new 40 bed active treatment hospital. High level of activity in Emergency, Surgery and Obstetrics offers challenge and the benefit of valuable experience for conscientious nurses. Previous experience an asset. Must be registered or eligible for registration in Alberta.

AHA/AARN Policies in effect.

Hinton is a modern, progressive, industrial town on the eastern slopes of the Rockies, 50 miles east of Jasper. Population 7,600. Unlimited year round recreational facilities.

Apply with full resume including experience and references to:

Director of Nursing  
Hinton General Hospital  
Box 40  
Hinton, Alberta  
T0E 1B0

## Summer Employment

### Registered Nurses

Nursing opportunities will be available for a 3 or 4 month period during the months of May, June, July, August 1980. Nurses will provide primary nursing care, be able to exercise clinical judgement and participate in a patient-family oriented program in our modern 300 bed teaching extended care unit. Interested nurses, who are eligible for registration in British Columbia should write to:

Hospital Employment Officer  
Health Sciences Centre Hospital  
University of British Columbia  
Vancouver, B.C.  
V6T 1W5

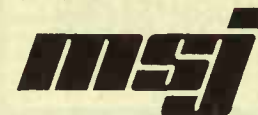
Positions open to both female and male applicants.

## Registered Nurses

300 bed Accredited general hospital in Vancouver requires full-time, part-time and casual R.N.s for general duty and ICU nursing. Candidates should be eligible for registration in B.C. Recent nursing experience preferred. ICU candidates must have previous ICU experience.

Please apply to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C.  
V5T 3N4



## Royal Jubilee Hospital

Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

## Head Nurse

Head Nurse required for Intensive Care Unit (6 bed) in an expanding 258 bed acute and extended care hospital in the Okanagan Valley.

Must be eligible for registration in B.C. Previous applicable clinical and administrative experience required. Advanced administrative education, BScN, and post graduate education in I.C.U. preferred.

To commence 1 August 1980.

Salary and benefits in accordance with R.N.A.B.C. collective agreement.

Apply, with resume to:

Director of Personnel  
Vernon Jubilee Hospital  
Vernon, British Columbia  
V1T 5L2

## School of Nursing

### Nursing Instructors

required for August, 1980 in a 2 year English language Nursing Diploma program

#### Qualifications:

Bachelor of Nursing with experience in Teaching and at least one (1) year in a Nursing Service position, courses in Teaching Methods and eligible for registration in New Brunswick.

Apply to:

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Director  
The Miss A.J. MacMaster  
School of Nursing  
100 Arden St.  
Moncton, N.B.  
E1C 4B7  
Telephone: 506-854-7330

International Grenfell Association  
requires immediately

## Assistant Director of Nursing

For accredited 160-bed general hospital in St. Anthony, Newfoundland.

Duties include assisting the Director of Nursing with the planning, organizing, directing and evaluating of the nursing services of Charles S. Curtis Memorial Hospital.

Accommodation provided at reasonable rates. Travel borne by the Association on minimum of one year service. Group life health insurance and pension plan offered. Other fringe benefits.

Applicants must be eligible for registration with ARNN. Post-basic preparation. Preferably a baccalaureate degree in nursing or other desirable combination of experience and training.

Salary in accordance with Newfoundland government scale.

Apply to:

Mr. Scott Smith  
Personnel Director  
International Grenfell Association  
St. Anthony, Newfoundland  
A0K 4S0

## Registered Nurses

Required immediately Registered Nurses only for a 90 bed hospital in Medicine, Surgery Paediatrics and Special Care Units.

Salaries according to Provincial Salary Guide.

Usual fringe benefits.

Apply to:

Director of Nursing  
Digby General Hospital  
Digby, Nova Scotia  
B0V 1A0

Telephone: 245-2501

Ungava Hospital  
Kuujuaq (Fort-Chimo), Northern Quebec

## Nurses:

for an 11 bed hospital at Kuujuaq and for Nursing Stations of Northern Quebec Inuit villages.

#### Qualifications:

- Minimum of one year of Nursing experience
- Bilingualism essential
- Ability to take responsibilities

#### Advantages:

- Knowledge of a new culture
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Please send your Curriculum Vitae to:

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Ste-Foy, Quebec  
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## The Aga Khan Hospital and Medical College, Karachi

SCHOOL OF NURSING

### Nursing Instructors

Applications are invited for 4 positions of nursing instructors immediately and additional instructors phased over 4 years.

The School is located in a modern facility which is due to be completed in June. The first class of students of a 3-year diploma program will be admitted late this year. The medium of instruction will be English.

Initially, clinical experience will be provided in selected Karachi hospitals until completion of the 721-bed Aga Khan Hospital in 1984.

#### Qualifications

Applicants must have a bachelor's degree in nursing or nurse-teacher qualifications and must be eligible for registration in Pakistan. Preference will be given to applicants with three years of nursing practice and at least 1 year of teaching experience. Teachers will participate in classroom and clinical teaching.

Competitive salaries will be offered depending on qualifications and experience. The initial contract period is three years. Relocation assistance will be provided.

Applications including a resume, recent photograph and names of three references should be addressed to:

**Ms. W. Warkentin**

Director

School of Nursing Aga Khan Hospital  
P. O. Box 3500 Karachi-5 Pakistan.

### Registered Nurses

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The truth is, you can't, without the guidance of job-market professionals who know the nursing business as well as the placement business. That's why, before you sign on that dotted line to-day, you should check with Recruiting Registered Nurses Inc. We're the Canadian Medical Placement Specialists throughout the United States.

R.R.N. has immediate positions available in:

California — Ohio — Pennsylvania — Michigan

Don't wait!!!! Call or write immediately for further information.

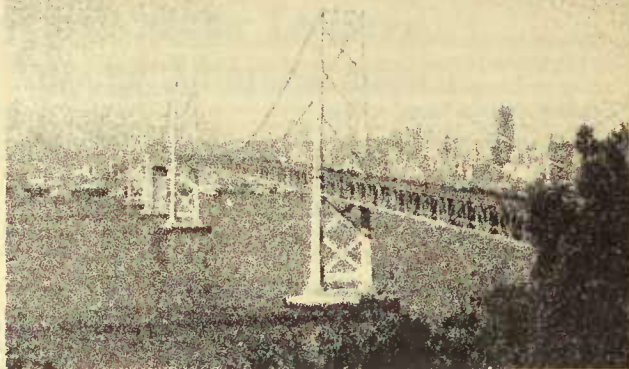
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Please submit a resume to or call COLLECT: Nurse Recruiter, Stanford University Hospital, Stanford, CA 94305, (415) 497-7330. An equal opportunity/affirmative action employer female/male/handicapped.

### I would like to know more about Nursing Opportunities at Stanford

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AA \_\_\_\_\_ BS \_\_\_\_\_ Dip \_\_\_\_\_ Yr \_\_\_\_\_

Area of Interest \_\_\_\_\_ code CAN20

**Stanford University  
Medical Center**





## Director of Nursing

Applications are invited for the position of Director of Nursing for the Central Peace General Hospital. The Hospital is a 50 bed, active treatment facility located in the heart of the Peace River Country at Spirit River, Alberta.

The applicants must be eligible for Registration with The Alberta Association of Registered Nurses, preferably hold a B.Sc. degree in Nursing and have at least five years experience in a responsible nursing position.

Applicants should apply stating experience, education, salary expected and date available for duty to:

**Mr. J. V. Bjork**  
Administrator  
Central Peace General Hospital  
Spirit River, Alberta  
T0H 3G0

## Team Leaders - Edmonton

The Eric Cormack Centre, provides residential accommodation and developmental opportunities for 92 dependent multihandicapped children and young adults. These persons will supervise and direct a team in providing for the health maintenance needs of residents living on a 24 bed unit.

**Qualifications:** Graduation from a recognized school of nursing and current eligibility for registration in the appropriate professional organization. Some exposure and experience in the field of mental retardation, as well as some supervisory experience would be an asset.

Salary: \$14,748 – \$17,340

Competition #9176-1 Open until suitable candidates selected.

For detailed information, request Job Bulletins and apply to:

Alberta Government Employment Office  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4

## Registered Nurses

1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including:

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

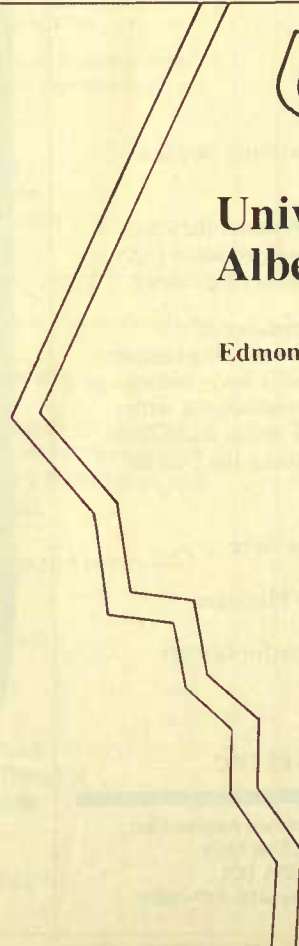
Planned Orientation and In-Service Education Programs.  
Post Graduate Clinical Courses in Cardiovascular—  
Intensive Care Nursing and Operating Room Nursing.

Apply to:  
Recruitment Officer — Nursing  
University of Alberta Hospital  
8440 — 112th Street  
Edmonton, Alberta  
T6G 2B7



## University of Alberta Hospital

Edmonton, Alberta





## Co-Ordinator Surgical Nursing Services

This 1100 bed community and teaching hospital invites applications for the position of Co-ordinator-Surgical Nursing Services. The area components are five nursing units plus a four bed intensive care unit, totalling 146 beds.

This person will be responsible for the overall delivery of quality patient care and management of the surgical services including budget control, staffing, staff development and other administrative duties.

Applicants must have an appropriate degree and significant clinical experience.

Please forward a resume detailing experience and qualifications to:

**Vivian Walwyn**  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C.  
V6H 3N1  
(604) 876-6767, local 271

## Registered Nurses

Applications are invited for full time and part time employment at Oshawa General Hospital, a 600 bed hospital, 48 kms. East of Toronto.

Successful candidates must be registered in Ontario.

Services provided include:

Medicine	Paediatrics
Surgery	Intensive Care
Obstetrics	Coronary Care
Emergency	Out-Patients
	Chronic/Rehabilitation

Salary Range: (Full time) \$1,450.00 - \$1,676.00 (monthly)

Inquiries may be directed to:

**Personnel Services**  
Oshawa General Hospital  
24 Alma Street  
Oshawa, Ontario  
L1G 2B9

## MITCHELL COLLEGE OF ADVANCED EDUCATION AUSTRALIA

Mitchell College is the largest country college of advanced education in Australia, situated at BATHURST NSW, 210 km west of Sydney. The College offers programs of study in Business and Administrative Studies, Teacher Education, and Liberal and Applied Arts to an enrolment of 4000 students.

Applications are invited for the position of

### Lecturer/Senior Lecturer in Nursing Administration

The appointee will develop study material and teach Nursing Administration units within the Associate Diploma in Health Administration which is a recognised professional qualification for nursing and hospital administrators in New South Wales. As the course is formulated on an integrated approach to health administration, the appointee will contribute additionally in those areas where his/her experience or qualifications are appropriate.

This is the initial nursing appointment in the Department of Management Studies and Offers the appointee the opportunity to provide personal and academic leadership to several hundred students. Applicants should have recent experience in nursing administration at a senior level and hold a degree in nursing or health administration or a good first degree with an emphasis towards management oriented subjects.

Further details of the position may be obtained from Dr R Garnett (063) 31 1022.

The successful applicant would be expected to take up the appointment in July/August, 1980.

SALARY and appointment level will depend on qualifications and experience -

Senior Lecturer 1	-	\$A24996 to \$A26622 per annum
Senior Lecturer 11	-	\$A22842 to \$A24458 per annum
Lecturer 1	-	\$A19923 to \$A22365 per annum
Lecturer 11	-	\$A17024 to \$A19465 per annum
Lecturer 111	-	\$A14673 to \$A16809 per annum

CONDITIONS of employment include an attractive superannuation scheme and a specially negotiated bank finance arrangement for building or buying a home. Fares for the appointee and family to Bathurst and reasonable removal expenses will be paid.

APPLICATIONS setting out personal data, telephone number, qualifications and experience, accompanied by the names and addresses of three (3) referees and a recent photograph of the applicant, should be sent to:

The Registrar (Staff Appointments)  
**MITCHELL COLLEGE OF ADVANCED EDUCATION**  
BATHURST NSW 2795  
AUSTRALIA

Applications close on Friday 20th June 1980

21576



**Health Sciences Centre  
Winnipeg, Manitoba**

invite applications for the position of

**Director  
School of Nursing**

A leadership position is available in a two-year diploma nursing school situated in a large teaching hospital, with an enrolment of approximately 200 students and 30 faculty and support staff. The school has an established curriculum based on an adaptation model. Responsibilities will include administrative and budgetary functions, student counselling and recruitment, on-going review of curriculum and policies, maintenance of a climate for teaching/learning and the overall maintenance of standards.

Applicants must be registered or eligible for registration with the Manitoba Association of Registered Nurses and have successful experience in both teaching and administration. Preparation at a Master's level in nursing is preferred.

The position is available in July 1981.

This position is open to females and males. Interested persons should apply in writing including a complete resume detailing education and experience to the:

**Manager Employment & Training**  
Health Sciences Centre  
700 William Avenue  
Winnipeg, Manitoba  
R3E 0Z3



## Fishermen's Memorial Hospital

### Director of Nursing

Applications are invited for the position of Director of Nursing for this 60 bed, active treatment hospital located on the south shore of Nova Scotia.

The successful applicant will report directly to the Administrator and will be responsible for the planning, organization and administration of the nursing services.

The applicant will have a successful background in nursing administration and preferably will have had academic courses in preparation for management.

Address all inquiries in writing, stating date available and salary expected to:

Harley K. Frowd  
Administrator  
Fishermen's Memorial Hospital  
Lunenburg, Nova Scotia  
B0J 2C0

## Assistant Director of Nursing

### Active Treatment

Required for a fully accredited 135 bed active care hospital.

#### The Position

As a member of the Nursing Administration Team, this nurse needs innovative qualities and ability to organize, delegate and direct the work of others. The applicant must have an enthusiasm for initiating and following up new ideas, projects and quality assurance programs.

#### Minimum Qualifications

Candidates must be currently registered in the Province of Alberta, and possess a Baccalaureate Degree in Nursing, with demonstrated competence and ability in a senior level nurse management position.

The position becomes available August 18, 1980, upon the retirement of the present incumbent.

Interested applicants may submit a comprehensive resume to:

Mr. Bruce Finkel, Director of Nursing  
Wetaskiwin General Hospital  
5505 - 50 Avenue  
Wetaskiwin, Alberta  
T9A 0T4

## Registered Nurses

Come to work in scenic Corner Brook!

Registered nurses are needed for this 350 bed Regional General Hospital, with detached 60 bed Special Care Unit, serving the West Coast of Newfoundland.

The hospital offers good fringe benefits such as four weeks annual vacation and eight statutory holidays plus birthday holiday. In addition there is a hospital pension plan and a group insurance plan for all permanent employees.

Accommodation and assistance with transportation is available.

Negotiated Salary Scale:

1 January, 1979 — \$12,771.00 — 15,429.00  
1 January, 1980 — \$13,410.00 — 16,199.00  
(Contract not yet signed)

Service Credits recognized.

Interested applicants apply to:

Mrs. Shirley M. Dunphy  
Director of Personnel  
Western Memorial Regional Hospital  
P.O. Box 2005  
Corner Brook, Newfoundland  
A2H 6J7

### Required:

General Duty Nurses for an acute care Hospital

(37 beds)  
27 - Adult  
10 - Paediatric  
10 - Bassinettes

#### Clinical areas included:

- Medicine - Surgery - Obstetrics
- Paediatrics - Operating Room
- Case Room and Delivery Room
- Emergency and Out-Patient Departments

Applications must be eligible for registration in Nfld.

Personnel policies in accordance with the Nfld. Nurses Union Agreement, 1980.

Salary Scale - Step 1 (at the present time) \$14,228.00.

Shift and Charge Nurse differential.

To rotate all three shifts.

Accommodation available in Residence.

Apply to:

Director of Nursing  
Channel Hospital  
Port Aux Basques  
Newfoundland  
A0M 1C0





Open to both  
men and women



# NURSES

## Solicitor General of Canada

Salary: Up to \$23,367 (under review)

Ref. No: 80-NCRSO-NU-15

**CLEARANCE NUMBER: 310-106-022**

The Correctional Service of Canada will have positions available at various locations across Canada over the next 12 months in Federal Correctional Institutions and special psychiatric hospitals.

**Salaries:** Up to \$23,367 (under review) - dependent on qualifications, assignment, and location - plus penological factor allowance of up to \$1,000 per annum. (under review)

### Opportunities

Correctional health care and forensic psychiatry provide new and expanding career opportunities for nursing professionals. These unique, challenging areas demand men and women with proficient nursing skills, special personal qualities, and a pioneering spirit.

### Responsibilities

In the Health Care Centres (HCCs), the nurses are the inmates' first contact with health care professionals. Each nurse must be independent, resourceful and prepared to operate in an expanded nursing role. In the Regional Psychiatric Centres (RPCs), the treatment philosophy emphasizes a multi-disciplinary approach encompassing all aspects of psychiatry. The primary therapist in each of these university-affiliated hospitals is frequently the nurse.

### Duties

Assist in the development of medical and psychiatric programmes for inmates in either health care centres or regional psychiatric centres and provide nursing care to patients on a 24 hour basis.

### Benefits

Excellent pension plan; good sick leave benefits; evening, night and weekend premiums; 11 statutory holidays; and a minimum three weeks holiday; continuing education opportunities and relocation expenses.

### Qualifications

- Registered Nursing diploma for HCCs and RPCs
- Registered Psychiatric Nursing diploma for RPCs
- Registered/Certified/Licensed Nursing Assistant diploma for RPCs
- Baccalaureat degree in Nursing an asset for HCCs and RPCs
- Recent general nursing experience required for HCCs
- Recent psychiatric nursing experience required for RPCs
- Administrative and supervisory experience required for managerial positions in HCCs and RPCs

### Language Requirements

For some positions knowledge of both English and French is essential. Because of the nature of these positions bilingual capacity is required immediately. Other positions require a knowledge of English, others a knowledge of French while others require a knowledge of English and French. Unilingual persons may apply for bilingual positions but must indicate their willingness to become bilingual. The Public Service Commission will assess the likely aptitude of candidates to become bilingual. Language training will be provided at public expense.

*"Additional job information is available by writing to the address below;*

*Toute information relative à ce concours est disponible en français et peut être obtenue en écrivant à l'adresse suivante".*

### For further information call (collect) or write:

Director, Nursing Operations  
340 Laurier Avenue West  
Ottawa, Ontario K1A 0P9  
Tel.: (613) 995-4971

### How to apply

Send your application form and/or résumé to:

Mrs. Joyce Bleakney  
Public Service Commission of Canada  
National Capital Region Staffing Office  
L'Esplanade Laurier, West Tower, 16th floor  
Ottawa, Ontario K1A 0M7  
Closing Date: March 31, 1981

*Please quote the applicable reference number at all times.*



Queensland Institute of Technology  
Brisbane - Australia

### Senior Lecturer in Nursing Studies

The Institute is a multi-disciplinary tertiary college with a student population of 7,500 located in sub-tropical Brisbane, Australia.

The Department of Nursing Studies, in the School of Health Science, currently offers Diploma of Applied Science courses in Nursing Administration, Nursing Education and Nursing Unit Management. A Community Nursing course is planned for introduction in 1981 and a basic nursing course is being developed. A new position is being created for a senior lecturer who will assist in the administration of nursing programs, and will exercise academic leadership in one or more special areas of competence in the discipline of nursing.

Applications are invited from registered nurses, preferably with experience in educational administration, who hold post-registration degree or diploma level nursing qualifications. Higher academic and/or professional qualifications are desirable, but other evidence of academic achievement may be acceptable. Salary ranges: \$A22,842 - \$A24,461; \$A25,000 - \$A26,623 p.a.

Conditions of service and general information may be obtained from the Personnel Officer, Q.I.T., George Street, Brisbane 4000 Australia.

Applications quoting V.32/80 together with full particulars, including telephone number and the names and addresses of three (3) referees to reach the Personnel Officer by April 30th, 1980.



### Director of Nursing

Applications are invited for this position in a forty bed acute care hospital located in beautiful Northern Saskatchewan.

We serve a population of 4,500 from a modern active community with all services and excellent recreational facilities. Successful applicant will be responsible for all nursing services including inservice education.

We have a nursing staff of 21 and a Medical Staff of three physicians including a general surgeon.

Fringe benefits include four weeks paid vacation after one years service increasing to five weeks after three years service; Group Insurance; Pension Plan and Disability Income Plan. Air transportation paid on hiring and for vacation. Private suite in modern residence available.

Salary is negotiable and will be commensurate with training and experience.

Resumes and inquiries may be submitted to:

**R. J. King**  
Administrator  
Municipal Hospital  
Box 360  
Uranium City, Saskatchewan  
S0J 2W0

or phone above person collect at 306-498-2412

## Interested in a Challenge? Try International Nursing - in Saudi Arabia!

The King Faisal Specialist Hospital and Research Centre, a 250 bed Acute Care Referral facility in Riyadh, Saudi Arabia, has current and/or periodic openings for experienced R.N.'s. Managed by the Hospital Corporation of America Group, the hospital is staffed with professionals from North America, Europe and the Middle East.

The Nursing Areas currently available are: NICU, L & D, PEDS, INSERVICE, CLINIC & RADIATION THERAPY. Requirements include three years current experience as an R.N. in an Acute Care hospital with at least one year in the specialty and a current R.N. license in one of the provinces. Verbal and written fluency in English. 2-Year contract commitment. Positions are single status.

Salaries are excellent and the exceptional benefits include 30 days paid annual leave, free transportation, furnished lodging, bonus pay and leave and more.

If you are a dedicated professional with a desire to make a contribution — to experience the unusual — to travel — to work side-by-side with people from around the world — then we'd like to hear from you.

**Don't Let This Once In A Lifetime Opportunity Pass You By**

For further information please contact:

**Kathleen Langan, R.N.**  
Hospital Corporation International, Ltd.  
Two Robert Speck Parkway Ste. 750  
Mississauga, Ontario L4Z 1H8

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# HOSPITAL CORPORATION INTERNATIONAL

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An Equal Opportunity Employer



### Head Nurse in our Obstetrical and Gynaecological Unit

The successful applicant will be responsible for the administration of the 24 bed Obstetric-Gynaecologic Unit, as well as the Labour and Delivery area and Nursery.

Will work with a co-ordinator who has additional responsibilities in the Paediatric Department.

Must be eligible for Registration in the Province of Ontario and should have demonstrated Administrative ability.

Ours is a 300 bed, fully accredited General Hospital serving a population of roughly 40,000 in this picturesque, culturally active, semi-rural community. We have good transportation links with the larger Southern Ontario Cities.

Application, including resume should be sent to:

Director of Personnel  
Stratford General Hospital  
Stratford, Ontario N5A 2Y6

### Toronto East General Hospital

Required for 600 bed hospital with expanded facilities. Minutes from downtown.

#### Registered Nurses:

Medical, Surgical  
Operating Room  
Critical Care Areas

#### Head Nurses:

Paediatric Unit  
Special Neonatal Care Unit

Applicants must have clinical and management experience in specialty and post basic educational preparation

All applicants must be eligible for Ontario registration.

Write to:

Miss H. Koski  
Staffing Office, A126  
Toronto East General Hospital  
825 Coxwell Avenue  
Toronto, Ontario  
M4C 3E7

### Director of Nursing

Applications are invited for the challenging position of Director of Nursing for Shouldice Hospital an 89 bed active surgery private hospital located 1 1/4 miles north of Toronto.

The successful applicant will be a member of the Management Team reporting to the Administrator and will be responsible for planning, organization and total administration of the Nursing Service.

The applicant should ideally have experience in nursing administration and possess a B.Sc.N. degree, but an equivalent combination of formal education and experience will be acceptable.

Applicants are requested to submit their resume to:

John J. MacKay  
Administrator  
Shouldice Hospital  
Box 370  
Thornhill, Ontario  
L3T 4A3

## ASSOCIATE EXECUTIVE DIRECTOR— NURSING

### MOUNT SINAI HOSPITAL, TORONTO, ONTARIO

Mount Sinai Hospital, a modern 510-bed fully accredited active teaching hospital, affiliated with the University of Toronto, requires an Associate Executive Director—Nursing, to provide continued leadership to an established Department of Nursing. In addition to the medical/surgical services and their sub-specialties, the Hospital has a short term, active Rehabilitation In-Patient Unit, which serves as a regional area of expertise, a Psychiatric Unit, and has recently been recommended as a Regional Perinatal Unit.

This position will report to the Executive Director and the individual will be responsible for planning, organizing, directing and controlling the activities of the Department of Nursing. Nursing education is provided to nursing students from the University of Toronto and from the Community Colleges. The Associate Executive Director—Nursing plays an important role in hospital programme formulation and in policy determination, as a member of the senior management team of the Hospital, and as a voting member of both the Medical Advisory Council and its Executive Committee. A University appointment is available for the appropriate candidate.

The suitable candidate will preferably have advanced preparation at the Master's Degree level and have a demonstrated record of nursing experience, including 3-5 years in a senior nursing position. The candidate must be able to work within an academic environment and must be able to provide leadership in furthering the patient care, teaching and research goals of the institution.

This position will become available November 1, 1980, on the retirement of the incumbent. Applications are now being sought and resumes should be forwarded to:

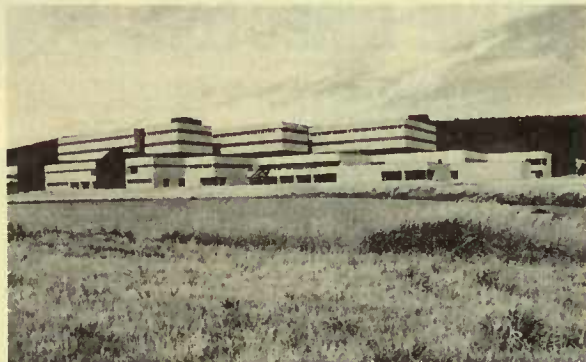
Executive Director  
**MOUNT SINAI HOSPITAL**  
600 University Avenue  
Toronto, Ontario,  
M5G 1X5



## **A Completely Modern Teaching Hospital**

### **Requires**

### **Registered Nurses**



This 500 bed general hospital is the major teaching facility for the Medical School of Memorial University of Newfoundland.

#### **Services offered -**

Critical Care, Medical, Surgical Coronary Care, General Surgery, Urology, Gynecology, Medicine, Nephrology, Clinical Teaching, Neurosciences, Cardiology, Cardiovascular Surgery, Orthopedics, Hemodialysis (kidney transplants), Emergency and Out Patient Services, active Rehabilitation Program (adult).

The Staff Development and Training Department offers ongoing lectures and demonstrations in addition to a 6 month diploma course (twice yearly) in — Critical Care Nursing, Neurosciences, Operating Room Nursing.

Located in St. John's, Newfoundland — the oldest city in North America with a population of 120,000, offering cultural and recreation activities in a friendly atmosphere.

Fishing, hunting, boating available approximately 10-14 miles outside the city.

For information regarding salary and relocation expenses and other conditions of employment write or call -

**Miss Dorothy Mills**  
**Staffing Officer - Nursing**  
**The General Hospital**  
**Prince Philip Drive**  
**St. John's, Nfld.**  
**A1B 3V6**

**Telephone # (709) 737-6450**

## **Head Nurse — Intensive Care Unit**

### **The Organization**

University Hospital is a progressive 540 bed university teaching hospital dedicated to providing exemplary standards of health care. In 1979, a \$40 million expansion project was completed, including new intensive therapy facilities.

### **The Position**

The successful applicant will report to the Director, Special Services Nursing, and will be responsible for the administrative and professional supervision and coordination of total patient care in a 19-bed combined medical, surgical, respiratory, coronary care and hemodialysis unit.

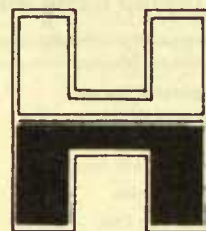
### **The Preferred Applicant**

The preferred applicant will have previous clinical experience in intensive care nursing, demonstrated teaching and administrative ability and preferably a Baccalaureate Degree in Nursing.

Salary level will be according to Saskatchewan Union of Nurses' rates of pay and recognition for experience and qualifications.

Submit formal letter of application with resume to:

**Employment Officer, Nursing**  
**Personnel Department**  
**University Hospital**  
**Saskatoon, Saskatchewan**  
**S7N 0X0**



## **Head Nurse - Obstetrics**

Applications are being accepted for this family centred unit which consists of 21 obstetrical and 7 gynecological beds, plus Nursery and Delivery suite. There are approximately 900 to 1000 births per year.

The successful candidate will be responsible for providing innovative and creative leadership as well as for the quality of nursing care and the administration of the unit.

Candidates should be currently registered with the College of Nurses of Ontario and have post graduate obstetrics experience (including fetal monitoring and Family Centred Care). Strong leadership, management and communications skills are essential, and graduates of the Nursing Unit Administration Course will be given special consideration. The possession of a B.Sc.N. degree would be a decided asset.

Please submit a resume, outlining qualifications and salary expectations, to:

**Staffing Co-ordinator**  
**Greater Niagara General Hospital**  
**5546 Portage Road**  
**P.O. Box 1018**  
**Niagara Falls, Ontario**  
**L2E 6X2**



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Telephone: (215) 363-6063

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The Canadian Nurse  
50 The Driveway  
Ottawa, Ontario K2P 1E2  
Telephone: (613) 237-2133

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**ccab**

# Wish you were here



## ...in Canada's Health Service

Medical Services Branch  
of the Department of  
National Health and Welfare employs some 900  
nurses and the demand grows every day.

Take the North for example. Community Health  
Nursing is the major role of the nurse in bringing health  
services to Canada's Indian and Eskimo peoples. If you  
have the qualifications and can carry more than the  
normal load of responsibility... why not find out more?

Hospital Nurses are needed too in some areas and  
again the North has a continuing demand.

Then there is Occupational Health Nursing which in-  
cludes counselling and some treatment to federal public  
servants.

You could work in one or all of these areas in the  
course of your career, and it is possible to advance to  
senior positions. In addition, there are educational  
opportunities such as in-service training and some  
financial support for educational leave.

For further information on any, or all, of these career  
opportunities, please contact the Medical Services  
office nearest you or write to:

Medical Services Branch  
Department of National Health and Welfare  
Ottawa, Ontario K1A 0L3

Name

Address

City

Prov.



Health and Welfare  
Canada

Santé et Bien-être social  
Canada



# Debrisan®

## cuts the cost of decubitus care

### by controlling infection fast

Debrisan sucks bacteria and toxins out of decubitus ulcers. The ulcer is quickly cleansed, healthy granulation appears, and healing can begin.

"These (wet, exudative ulcers) averaged two days to clear the superficial infection and five days from the onset of therapy to appearance of good granulation tissue in the ulcer base."<sup>1</sup>

### by relieving pain and odour fast

"All patients in whom rest pain was present at the start of treatment noticed almost immediate relief of the rest pain when Debrisan was applied to the wound."<sup>2</sup>

"Debrisan was commenced and the following day, the smell had disappeared."<sup>3</sup>



Day 0 Infected, heavily exudating decubitus ulcer on left hip.



Day 2 Exudate diminished. Erythema and edema reduced.



Day 14 Clear, healthy granulation base; grafted successfully.



Day 0 Infected exudating decubitus ulcer on knee.



Day 4 Clear, healthy granulation base.



Day 14 Ulcer healing after Debrisan discontinued.



Day 0 Undermined sacral decubitus ulcer infected with *Pseudomonas* and *E.coli*.



Day 7 Surgically debrided before Debrisan therapy and after 7 days, infection controlled.



Day 28 Appearance on healing.

### by saving valuable nursing time

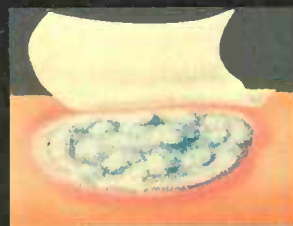
Only one Debrisan change a day\* is needed. Debrisan therapy can be stopped as soon as all signs of infection have gone and the ulcer is clean and granulated.

"Debrisan appears to be, in my opinion, just what we as nurses are seeking."<sup>4</sup>

\*Two, if exudation is very heavy.



After removing crust or necrotic tissue, pour a thick (4 mm) layer of Debrisan on the ulcer.



Cover with a dressing.



When the beads are saturated (12 to 24 hours later) rinse and wipe them away. Apply a fresh layer of Debrisan.

### Debrisan® cleans decubitus ulcers fast.



Pharmacia (Canada) Ltd.  
Dorval, Québec

#### References

1. Lim LT, Michuda M, Bergan JJ. *Angiology* 29:9, Sept 1978
2. Bewick M, Anderson A. *Clin Trials* 15:4, 1978
3. Saul J. *Brit J Clin Pract*, 32:3, June 1978
4. DiMascio SRN. Decubitus Care A New Approach: A Nursing Responsibility, on file at Pharmacia (Canada) Ltd.

Reg. T.M.





# Today's Diabetics.

Through good control, they're enjoying better health and a healthier outlook. And Ames is helping.

Today's diabetics have a healthier outlook on life. And it's all because they're in control of their condition. They watch their diet. Get the exercise and therapy they need. And keep a check on themselves with daily urinalysis.

That's where Ames helps out.

Our Diastix\* or Keto-Diastix\* tell them day by day where they stand with their condition, so there's less risk of complications than ever before. And the cost is just a few cents and a few seconds a day.

Our free Daily Diary helps them keep a record of their condition, so they can begin to see

how, when and why it changes.

And our free Diabetic Digest offers lots of useful information that may help them understand their condition more clearly and control it more effectively.

The only other thing they need is your guidance and advice. With that, and a little help from us, today's diabetics can enjoy better health and a healthier outlook.



**Ames  
Division**

**MILES\***

Ames Division, Miles Laboratories, Ltd.,  
Rexdale, Ontario M9W 1G6.

**We helped make urinalysis  
the science it is today.**



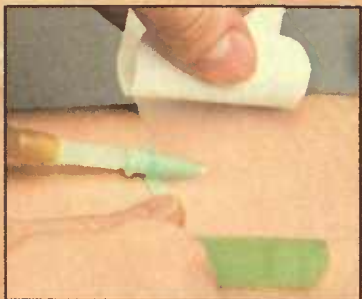
# NEW Op-Site® I.V. DRESSINGS

## So easy, so fast, so safe!

### Applied in seconds



Just peel the pouch open.  
Op-Site is sterile and ready to  
apply.



Apply Op-Site on the clean, dry  
i.v. site, right over the catheter.  
Leave Op-Site undisturbed until  
the catheter is changed!

### Op-Site is comfortable

It fits like a second skin, and its  
hypoallergenic adhesive  
minimizes the risk of skin  
irritation.

### Op-Site is transparent

It's the only dressing that allows  
direct observation of the site  
without being removed. Op-Site  
lets you spot i.v. problems the  
minute they occur!

### Op-Site secures the catheter

firmly to the skin, to help pre-  
vent catheter movement and  
vein irritation.

### Op-Site is bacteria-proof

Under Op-Site, i.v. sites are pro-  
tected from contamination,  
because no pathogens can  
penetrate Op-Site. And Op-Site  
is waterproof, too.

## Simpler, safer catheter care

Op-Site is the only dressing that secures i.v. catheters while helping to keep the site sterile. It goes on in one easy step, and stays on until the catheter needs to be changed!



**Smith & Nephew Inc.**  
2100, 52 Avenue  
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# The Canadian Nurse

JULY/AUGUST 1980

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Attitudes to aging are the focus of this Summer issue of CNJ...physiology, reality orientation and nutrition are all discussed in articles by nurses and a dietitian. Plus, an editorial comment from one of this country's most respected senior citizens, Senator David A. Croll. Our cover photo is courtesy of Health and Welfare Canada.

# The Canadian Nurse

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*The Canadian Nurse* welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

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# perspective

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## A GERIATRIC CRISIS

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*Senator David A. Croll, Q.C.*

Social welfare was born in Canada in 1909 when the Annuity Act was made law. From its inception it was popular and much used by the less fortunate of this country.

During the Depression, many of the poor, always fearful that their contract with the government would be cancelled if they did not pay the monthly amount due under the contract — it never was — often sent in stamps and sometimes nickels and dimes, so great was their desire to have something to look forward to at the end of the day.

In 1927 the government passed the Old Age Security Act authorizing payment of \$20.00 a month to those 70 years and over who passed the means test.

In 1952 a new blow was struck when the Old Age Security Act was stripped of its means test and applied on a universal basis. This was meaningful progress.

Eventually, the minimum age was reduced to 65 and now those who receive the Old Age pension are entitled to and receive about \$185.00 a month, a figure now being indexed.

The next vital step was to proclaim Medicare and make it available to all under all circumstances; this was to be free medical service to all Canadians. It has not turned out quite that way but corrective steps are in the making.

This is one of our greatest achievements and one which I believe we must guard with all our strength. It is the cornerstone of our social welfare system.

Then about fourteen years ago came the Canada Pension Plan which since its inception has also fallen short of our expectations. The recent report of the Special Committee of the Senate on Compulsory Retirement and Pensions indicates that the pension reality in the country is uncertain and unsatisfactory.

The report, "Retirement Without Tears", has had wide acceptance and created an interest in pensions that will soon be pursued by government. All political parties have indicated their support for doing something effective with pension legislation.

Old Age Security, Medicare and Canada Pension Plan form the basis of our social security system in Canada. I believe it is the responsibility of the nursing profession to take an active and prominent part in maintaining and preserving these measures, particularly Medicare which is so dependent on nursing and all that that profession implies. An imaginative approach is called for.

Our older people are now living 18 years past 65 for women and 15 years past 65 for men. This is a blessing; it is also an achievement and should be treated as such.

We need these over 65's in order to provide a meaningful pension for themselves and to contribute to a pension fund for as long as they work so that the younger people will not be paying too much for the pensions of older people.

The new situation is that there is a second or third career after 65 which cannot be satisfied by retirement.

Since this development involves older people, it inevitably also involves nurses. The geriatric crisis is now upon us. Here is an opportunity for meaningful leadership to open new avenues for preventive medicine, our weakest aspect so far of Medicare.

The problems that will be involved are of increasing concern and so an in-depth study of the opportunities for service should be made at the earliest date.

Nurses have a unique responsibility and obligation to serve our older citizens and to help solve the problems that will inevitably be brought upon us by longer living. There must be a new dimension to their contribution to the fastest growing portion of our population.

*The Hon. David A. Croll has served as chairman of two major reports on the problems of aging in Canada, The Senate Committee on Aging (1966) and Retirement Age Policies (1977). He was also chairman of the Special Senate Committee on Poverty. Now 80 years of age himself, he remains an active member of the Senate to which he was appointed in 1955.*

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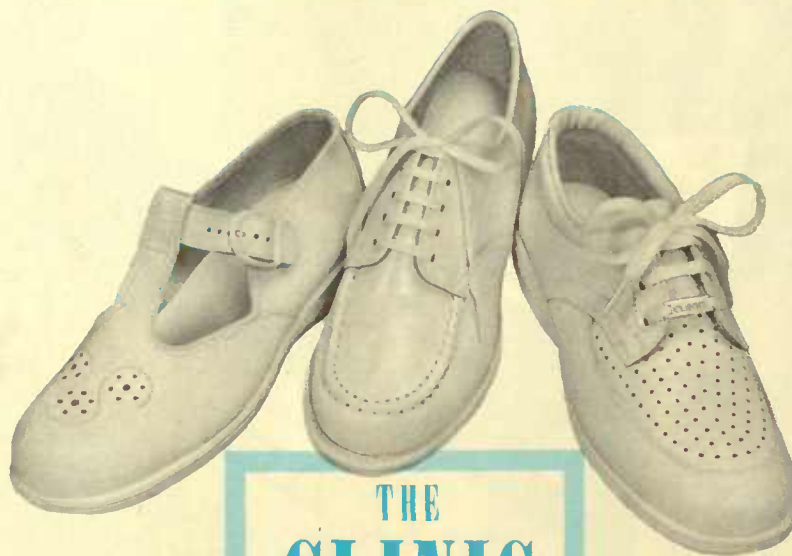
Notice to CNA members  
Re: *CODE of ETHICS*

Directors of your association, at a June pre-convention board meeting in Vancouver, approved a motion that the section of the CNA Code of Ethics containing references to "the withdrawal of needed services" be deleted and a substitute section be developed by an ad hoc committee appointed by the Board of Directors. This committee has been appointed and further information will be available through *The Canadian Nurse*.





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# calendar

Contributions to CALENDAR are published free of charge as space permits. For more than one insertion or to ensure publication in a specific issue, please consult our advertising department.

The 16th annual conference of the Association for the Care of Children in Hospitals will be held May 10-14, 1981 at the Royal York Hotel, Toronto, Ont. Papers, abstracts and workshop proposals may be submitted until August 31, 1980. Contact: *ACCH 1981 Conference Office, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G 1X8.*

The University of Alberta will offer the following nursing workshops in the fall of 1980: Planning and Implementing Staff Development, Sept. 8-9; Health Assessment, Dealing with Neurotic Behavior, Sept. 25-6; Dealing with Anger, Oct. 17; Handling Patient Discharge Effectively, Nov. 6-7; and Instructional Skills for Nurses, Nov. 13-4. Contact: *Millie Pasenko, Faculty of Extension, University of Alberta, Corbett Hall, Edmonton, Alta. T6G 2G4.*

"Meeting the Challenge" The rehabilitation of the traumatic brain-injured adult is the topic of a conference to be held at the Holiday Inn, Toronto, Sept. 18-9. Contact: *Centennial College, c/o Debby Banks, Ashtonbee Conference Center, P.O. Box 631, Station A, Scarborough, Ont. M1K 5E9.*

The annual meeting of the Inter-Urban Spinal Cord Association will be held Sept. 25-6 in Ottawa, Ontario. Contact: *Mrs. Carol Anne Clarke, c/o The Royal Ottawa Hospital, 1145 Carling Ave., Ottawa, Ont. K1Z 7K4.*

"Respiratory Care for the Critically Ill" is the theme of the Conference of the Toronto Chapter of the American Association of Critical Care Nurses to be held Sept. 29-30 at the Holiday Inn, Toronto. Contact: *Toronto Chapter A.A.C.N., P.O. Box 37, Postal Station Z, Toronto, Ont. M5N 2Z3.*

The third international Seminar on Terminal Care will be held Oct. 6-8 at the Queen Elizabeth Hotel, Montreal. Contact: *Post-Graduate Board, Royal Victoria Hospital, 687 Pine Ave. W., Montreal, P.Q., H3A 1A1.*

The Ontario Assembly of Emergency Care will hold this year's conference at the Skyline Hotel in Toronto, Oct. 6-8. Contact: *Ontario Assembly of Emergency Care, P.O. Box 550, Vineland, Ont. L0R 2C0.*

A three week course in Rehabilitation Nursing will be held at the Wascana Hospital, Regina, Sask., Oct. 14 to 31. Contact: *Shirlean Gear, Coordinator, 1980 Rehabilitation Nursing Course, Wascana Hospital, 23rd Ave. & Ave. G, Regina, Sask. S4S 0A5.*

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# News Feature Annual Meeting Roundup

## BRITISH COLUMBIA

Almost five years to the day after approving the creation of an autonomous Labor Relations Council that would operate within the framework of a restructured professional association, BC nurses have authorized directors of their association to conduct an examination of the legal relationship between the two bodies and "to take whatever steps are necessary to resolve this issue in the best interests of the members of the RNABC." Discussion of the nature and extent of the involvement between the two bodies — now and in the future — became an unscheduled priority item on the agenda of the 1980 three-day annual meeting in Vancouver early in May and resulted in a special evening session.

The amended resolution finally approved by membership directed elected officials to examine the situation as quickly as possible and "in their examination to seek a continuing involvement of the Labor Relations Council." Members also requested that they be kept fully informed of developments as they occur.

Trouble on another front was predicted by RNABC president Stephany Grasset in her report to membership who described nursing shortages in some areas as "critical" and said that too often nurses are not able to give even minimal care — "the bare bones of safety." Grasset, who said that nurses are being driven away by intolerable working conditions and lack of authority to do something about it, pointed out that "responsibility without authority is a burden that becomes intolerable after awhile."

"Even money," she said, "will not be enough to bring these nurses (who have left nursing) back." She reminded her audience that a shortage such as the current one in BC had been forecast several years ago by the executive director of the national association,

Dr. Helen K. Mussallem who predicted that a decline in status of the nursing profession in that province would result eventually in a manpower shortage. BC schools of nursing have traditionally supplied less than half of the number of new nurses needed annually. Last year only about one third of new registrants were BC graduates.

## Preventing burnout

"Conflict can be a growing experience" was the message keynote speaker Dr. Frances Storlie brought to her audience. Dr. Storlie who is associate professor of nursing in the graduate program at Orvis School of Nursing, University of Nevada, Reno, focused her remarks on the coping behaviors available to nurses in conflict and the steps that they can take to prevent professional discouragement and "burnout". Conflict takes root at the crosspoint of incompatible values," Dr. Storlie said. "It is a natural outcome when nurses with differing values practice in the same setting." She described the nurse in conflict as "one whose values or ideals are at odds with her surroundings" and pointed out that, "when the solitary nurse is cast against the background of the group, this conflict is poignant, raw and very, very lonely."



Dr. Frances Storlie

The good news, Dr. Storlie said, is that conflict can have a positive outcome. The nurse learns to recognize shortcomings in herself without being devastated by that knowledge. "Her belief in herself as a professional is

strengthened and she begins to walk the road of attainment again, this time with increased understanding of her goals, stronger after the detour."

Five nurses whose practice reflects different aspects of nursing took part in the panel discussion on rewards in nursing that followed Dr. Storlie's presentation. The five were: Lorna Janze of Hazelton, head nurse in a small hospital 750 miles north of Vancouver; Diane Porter, general duty nurse, Mills Memorial Hospital in Terrace; Mohamed Rajabally, educator, Okanagan College, Kelowna; Georgina Dingwall, nurse practitioner, Mayne Island; and Lynn Woods, a nurse with 12 years experience who has left nursing "for awhile or for good" to return to school.

Rewards in nursing, according to the group, include personal growth and satisfaction from "hands on care". Most agreed, however, with panelist Mo Rajabally who declared, "Whether we like it or not, we're living in a pressure cooker. It's a tough life being a nurse."

## Resolutions

Members approved upwards of a dozen resolutions, including one authorizing directors to begin a search for more adequate office space and parking to house RNABC staff and membership facilities. The building now in use was purchased when membership was 10,528, compared to the present figure of almost 23,000.

Other resolutions submitted by members and approved by voting delegates urged action in the following areas:

1. Health education — the incorporation of health education in teacher training, extension courses in health education for teachers and students, and inclusion of health education in school curriculum planning.
2. Health services — provision of adequate and appropriate long term psychiatric facilities and services for adolescents, increased funding for child care and better protection of the public and environment from



the dangers involved in transporting hazardous products by road or rail.

3. Association policy and member services — acceptance in principle of making the office of association president a full time salaried position, reimbursement of legal costs incurred by members appearing before the RNABC discipline committee, board of directors or provincial courts who are subsequently exonerated, a position statement on affirmative action and equal opportunity for women, provision for no-charge long distance calls from members to the association offices.

A number of resolutions were defeated, including proposals to increase the yearly allotment to chapters, to define the responsibility of the nurse in giving information to children, to support in principle a woman's right to choose whether or not to have an abortion, to provide child care facilities at annual meetings of the association, to videotape proceedings of these meetings for the general membership, and to urge the establishment of a central health registry.

## MANITOBA

"Nurses in the year 2000 need not be concerned with preventable diseases in the Third World, if, in the next 20 years, they can make a legitimate impact on health care." Dr. Helen Mussallem, keynote speaker at the annual meeting of the Manitoba Association of Registered Nurses was looking at the goal of the World Health Organization "Health for all by the year 2000".

Speculating that nurses, internationally, will be the magic ingredient in reaching this goal, Dr. Mussallem predicted that "Canada and other developed countries will be faced with the problems of affluency, that is, the diseases of choice, the self-imposed diseases and that these will be the major problems for nurses who will be on the front line of health care."

But if nurses in the year 2000 are to realize their potential, nurses now must take giant strides. Dr. Mussallem reminded her audience "that currently,

over 80 per cent of registered nurses in Canada are employed in hospitals where they do not have the opportunity to alter the course of events that bring the patient to the hospital; only nine per cent of our registered nurses work in settings where the primary concern is not illness. Over 80 per cent of our nurse manpower, more than 208,000 RN's, are located in a setting that addresses itself to about 15 per cent of the actual health care problems and, to compound this, Canada continues to spend about 95 cents of every dollar on illness care."

Members of MARN attending the two-day meeting in Winnipeg, May 22 and 23 were also addressed by Sister Simone Roach on Research and Ethical Issues, Roblin Tamblin on Specialization, Pat Wallace on Standards of Nursing Practice, and Dr. Shirley Stinson, CNA president-elect on Nursing Education and Continuing Education. Dr. Stinson predicted that, in the future, many of our questions involving nursing education will remain the same but our solutions will be quite different as we determine how we can best use technology. "By the year 2000, nurses will receive a substantial part of their basic education via television satellite and home-based computers and they will obtain their basic clinical nursing experience in a wide variety of health care settings, including factories and sea-based oil rigs."

Dr. Stinson did express some concerns for the future of nursing. "If nursing administration teaching is not strengthened, then by the year 2000 health administration will have taken over that role." She emphasized the need for nursing to look more closely at curricula and especially to recognize the present unacceptable reality of a total lack of educational facilities within Canada for preparation of nurses at the doctoral level.

Looking at local issues, Louise Tod, executive director of MARN, delineated the realities of the increasing shortage of registered nurses within the province. "In the fall of 1979 an acute shortage of registered nurses was apparent in Manitoba and across Canada. A survey of

250 acute care and personal care homes in Manitoba was carried out. The 161 replies revealed 262 full time and part time vacancies as of January 15, 1980." She stated that a breakdown of membership statistics comparing 1979 to 1976 memberships revealed 265 fewer nurses returning to nursing, 258 fewer new nurse registrants from outside of the province, and 91 fewer Manitoba diploma graduates in 1979.

In an attempt to compensate for this shortage and to deal with an increased demand for nurses to return to work, there has been a renewed interest in refresher programs. It is hoped that the number of graduates from these programs will increase from 69 in 1979 to a total of 110 by December 1980.

The Manitoba Minister of Health, the Honorable L.R. Sherman sees the potential shortage of nurses as one of the major challenges facing his department. He said that meeting and minimizing any shortage of nurses and development of recruitment programs for nursing professionals has become a priority item. He then invited MARN to join with the provincial Department of Health "in identifying the basic reasons for the peaks and valleys in nurse supply."

On the final day of the meeting membership voted on resolutions to direct their board for the coming year. First and most controversial of the resolutions accepted by members involved increasing MARN fees to \$100 annually for all practicing registered nurses and \$40 annually for non-practicing registered nurses. Two other resolutions reflected the current nursing shortage: the board of directors of MARN was instructed to fund a career film clip for television use directed to the mature student and suggesting nursing as a career. The board will also discuss with representatives of Red River Community College the feasibility of developing a special condensed and enriched nursing education program for out-of-country registered nurses who have been unable to meet the requirements for registration within the province of Manitoba.



President Marguerite Bicknell

Other resolutions passed focused on:

- **occupational health nursing:** the development and interpretation of guidelines for OHN; encouraging of the Manitoba government to employ a second OHN consultant; asking the Canadian Nurses Association to request an OHN consultant be hired at the federal level and approaching the provincial government to change the Code of Practice for Workplace Safety and Health Committees to allow the OHN to attend the Safety and Health Committee in an advisory capacity;
- **nursing administration:** MARN will support the CNA's belief that the executive responsible for the department of nursing shall be an educationally qualified registered nurse who is a member of the senior hospital administrative staff, reporting directly to the chief executive officer. MARN will also approach CNA to request the Canadian Council on Hospital Accreditation to enforce this standard;
- **specialization:** an ad hoc committee is to consider the question of specialty registries at either the provincial or national level;
- **recognition of excellence:** the board is to investigate the feasibility of establishing an award to recognize excellence in the practice of nursing.

Plans are already underway for next year's meeting, September 30 through October 2, 1981. Following suggestions from membership, the MARN annual meeting will now be held annually in Winnipeg in conjunction with the Manitoba Association of Nursing Students annual conference. ►



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## SASKATCHEWAN

The Saskatchewan Registered Nurses Association has followed the lead of Manitoba and Alberta in agreeing to investigate establishment of two levels of nursing, one of which will be designated as "professional" and will require baccalaureate level preparation. SRNA members attending this year's annual meeting also approved, by a narrow margin, a target date of 1990 for implementation of this requirement for those entering practice for the first time. The baccalaureate requirement, if it is implemented, will not jeopardize the standing of SRNA members already practicing, but will apply only to new graduates registering for the first time in Saskatchewan.

A total of 470 nurses turned out for the association's 63rd annual meeting in Saskatoon in May. One of their major accomplishments during the three-day meeting was approval of 33 recommendations containing directives for SRNA activities over the next five to 15 years. The recommendations are contained in the report of a task committee set up in 1977 to investigate the status of nursing in the province and presented to the annual meeting.

The report identifies the need for nursing research, changes in nursing practice, additional funding for the continuing education of nurses, and a strengthening of the role of the nurse administrator.

The report also notes the "province-wide need for additional university credit courses for nurses and supports the development of a masters program at the College of Nursing, University of Saskatchewan, and the establishment of a baccalaureate program in nursing at the University of Regina. The association is also urged to investigate methods of transferring course credits obtained in diploma nursing programs to degree programs for registered nurses.

Action on the report's recommendations as approved by membership will be determined by the SRNA Council.

## President's address

In her presidential address Betty Hailstone warned nurses of the possibility of "a critical shortage of manpower" and called on them to demonstrate flexibility and ingenuity in meeting the challenges of the coming decade. She cited the Nightingale Nurse Group who have established a group private practice in Saskatoon as "pioneers in alternate methods of health care delivery" and suggested that refresher courses, day care centers, new conservation methods with regard to supplies, equipment and recycling of resources would all have to be investigated. "Nursing in Saskatchewan," Hailstone said, "has been recognized as a humanitarian service and we must ensure that, with progress, the humanitarian ethic which is the basic component of our profession is maintained and strengthened."

## Resolutions

Health promotion was the focus of most of the 20 resolutions passed at the meeting. Members directed the SRNA to:

- push for legislation designating non-smoking areas
  - encourage members to become familiar with the skill of breast self-examination
  - encourage health education programs on BSE
  - encourage nurses to become certified in cardiopulmonary resuscitation at the Basic Rescuer Level
  - request government funding for programs leading to the prevention of substance abuse and the treatment and rehabilitation of alcohol and drug abusers
  - assume a more assertive role in speaking out on health issues and concerns.
- Members also urged the SRNA to "initiate action and provide funding" for a nursing research center in the province.

The theme of the meeting was "assertiveness for nurses". Keynote speaker, Dr. Carolyn Clark, told nurses that the reason they often had difficulty asserting themselves was that they were women who have been socially conditioned to stifle assertiveness in their homes, in their nursing education programs and in the work



place. Clark defined assertiveness as the process of setting goals, acting on those goals and taking responsibility for the consequences. She differentiated between aggression and assertiveness by saying that aggressive behavior does not accept responsibility for one's actions and instead blames others.

A new president-elect and three members-at-large were elected during the meeting. They are: Catherine Peters, Saskatoon, (president-elect); Eithne Reichert, Saskatoon; Carole Skulski, Saskatoon; and Phyllis Wise, Regina.

SRNA life memberships were awarded to Belle Berenson of Regina, Anne Graham of Moose Jaw and Sister Agnes Schachtel of Humboldt.

## ONTARIO



President Jocelyn Hezekiah

"There is nothing incompatible with being a member of a union and a member of one's professional organization. Our professional association is the one body that cuts across class and status lines and through which collective action can be taken on a provincial scale. Our divisiveness stems, not from unionism but from our attitudes towards each other and our communication — or lack of it — with others, nurse managers, educators, administrators, specialists or whatever."

Jocelyn Hezekiah, president of the Registered Nurses Association of Ontario in her address to the annual meeting reminded members that there will always be tension between managerial and non-managerial nurses

but this tension can and should be used creatively towards innovation of new and improvement of existing patient care systems and methods of health promotion.

"It has been said that possibly the greatest stumbling block to unity is our lack of a homogeneous basic education program to prepare individuals to practice as registered nurses. Today's nursing education should really be preparing tomorrow's nurses to meet future health needs of patients and clients," she said. In the '80's nurses must look seriously at the need for continuous learning to maintain clinical competence, even "...the majority of nurses in managerial positions are not adequately prepared to enter the executive jungle possessing both the financial and interpersonal skills required for the role." Hezekiah reflected that nursing's ability to change, to accept new roles and to adapt to changing societal needs promises a very exciting future for our profession.

This concept of the fluidity of the nursing role was also emphasized by Dr. Mary Vachon, a research scientist and psychiatric nurse with the Clarke Institute of Psychiatry, Toronto, who presented the Laura Barr lecture in honor of the former executive director of the RNAO. Barr is currently assistant executive director, Patient Services, Sunnybrook Medical Centre.

Vachon feels that nurses must face the challenges of the future by working to define their role, which may be broad, working to develop new roles and accepting the patient as the center of their prime commitment to these new roles. She proposed some ways in which nurses could make personal changes in their lives, caring for themselves, so that they can then make changes as a profession and eventually change the systems in which they operate.

In her speech entitled "Care for the Caregivers" Vachon looked at the areas in our lives in which stress is manifest and which we can alter to decrease stress. She identified danger signals of the initial development of stress and gave some suggestions on how best to

cope. "As nurses look towards the future, they must reassess the concept of power and see it from a more female perspective, as a way of promoting change. As a group we must recognize that others see us as competent and value our opinions, as individuals we must remember that if we are confident and do not feel like handmaidens then most often we will not be treated as one. As more nurses develop an increased sense of self-esteem and autonomy it will be possible to make the changes necessary to bring us into the twenty-first century."

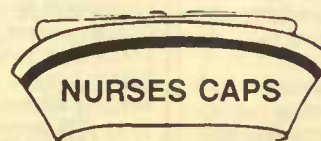
After a year of functioning under the completely revised set of bylaws, the restructured RNAO met from May 1 through May 3 in Toronto to assess the results of these changes and to set new priorities. Executive director Maureen Powers, in her report to membership, cited continuing problems in membership numbers as a major contributor to current RNAO issues. "Our capacity to act with collective strength, wisdom and vision relates directly to the numbers of registered nurses the association represents. The

future course of nursing may well be determined by our ability to maintain a vital, assertive and responsive organization. As individual registered nurses, each one of us is fully accountable for the determination of that future" she said.

Much of the direction to be followed by the RNAO in the coming year will result from implementing resolutions passed by membership. Some of these are intended to promote:

- consideration and discussion of the current status of nursing services provided to native Canadian Indians in Ontario
- liaison by the RNAO with the Registered Nurses of Canadian Indian Ancestry
- encouragement of the recruitment of native Canadian Indians into nursing programs
- promotion of the use of the awareness program "Breast Feeding" (Health and Welfare Canada) as a teaching tool for registered nurses
- urging of the Ontario government to introduce legislation to codify the common law such that any person, regardless of age, may give a consent to health care

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- support of the international boycott of Nestle products to discourage further provision of infant formulas in third world countries.

The final day of the meeting included sessions on topics ranging from professionalism, burnout, quality of work life and the nurse in the courtroom, to a look at the future and the challenges and choices available.

A lecture by Sheila Kieran, deputy executive director, Multiple Sclerosis Society of Canada brought the annual meeting to a close. Kieran's topic of "Responsibility for others" focused on the women's movement, its past mistakes and potential for a more positive future. "Be aware that we have met the enemy and they are us," Kieran said. She suggested that we face the future with an ever growing respect for our individuality and personal strengths and build upon the idea "each according to her ability, each according to her need."

## NEW BRUNSWICK

New Brunswick nurses attending their association's 64th annual meeting in Fredericton this year approved major revisions to the by-laws governing the conduct of NBARN affairs. Chief among the changes resulting from the amendments are:

- election of officers by secret ballot at the annual meeting each year instead of mail ballots
- clarification of the procedure to be followed in the handling of complaints concerning the professional conduct of registrants
- a \$10 increase in annual membership fees, bringing the 1981 fee for practicing members to \$105
- introduction of a system of proxy voting which will permit each practicing member attending an annual meeting to carry the votes of up to four other practicing members
- use of the term Board of Directors instead of Council to refer to the 25 persons charged with

management of the association affairs.

Changes in the handling of disciplinary charges against nurse members are designed to formalize existing procedures in such a way as to ensure impartiality and justice for the individual, while continuing to protect the public. Under the new system, a Complaints Committee will handle preliminary investigations. This body will have the power to dismiss a complaint or to recommend action by the Board of Directors. Complaints concerning alleged health problems will be referred to a Review Committee. All other complaints will be heard by a Discipline Committee.

## Nurse power

Keynote speaker Jenniece Larsen, looking at "Nurse power in the '80's", described nurses and nursing care as "the glue that keeps the health care system running."

"Without nurses," she reminded her audience, "hospitals do not run at all. We have tremendous power if we would just recognize it and learn to use it."

Larsen, who is assistant professor in the Faculty of Nursing at the University of Alberta, cited the provision of adequate day care for children of hospital employees as one possible change nurses could bring about that would result in better patient care and happier nurses.

"It seems almost obscene that one of the richest nations in the world should have totally inadequate day care. Hospitals in Alberta must provide parking lots for cars—but not provision for the care of the children of nurses. Then when the nurse cannot come to work because she has no baby sitter, we all shake our heads when some male administrator says that nurses are not committed workers."

"Next time you are without adequate day care, do not stay home, come to work and bring your child. I suspect the hospital would soon find a solution to the day care problem if there were kids hanging out of hospital windows and running in the hallways."

"This is an example of how to use power and will work most effectively in a

situation where there is a shortage of nurses or where nurses plan together as a group."



Jenniece Larsen

## Resolutions

President Anne Thorne noted that the majority of resolutions to come before this year's meeting related to the quality of nursing care in the province. "There are signs," she noted, "that we should be concerned also with the quantity of care... hopefully we can get a handle on this issue."

Among the resolutions approved by members were several intended to facilitate the process of obtaining a post-RN degree for nurses throughout the province. Members also approved the provision of mandatory malpractice insurance for NBARN members. A resolution expressing opposition to statements contained in the new CNA Code of Ethics received almost unanimous acceptance by members.

## NOVA SCOTIA

"Change and technology have made us more efficient in health care, but have they made us more effective?", asked Milton Orris, director of the health administration program, Community Health Division, University of Toronto, who opened the 71st annual meeting of the Registered Nurses Association of Nova Scotia at Acadia University. Orris said there are three main reasons for change — change for the sake of change, external forces which change the environment and over which you have little or no immediate control, and internal forces which you as a profession recognize and carry out.

"The economy isn't

going to change much — we in the health industry will continue to get more money each year, more than any other public sector but we are always going to need more than we get so we must manage it better and begin to make harder decisions," said Orris.

The conference theme, "Expectations of the nurse in the eighties" was explored from the point of view of the consumer, the government and the hospital administrator, with representatives from each sector.

Hospital administrator, Peter Mosher, executive director of the Kentville Hospital Association told the nurses they should get their act together and provide some answers to help hospital administrators by doing research in nursing and by the education of nurses to fit the demands of the market.

Anita Dubinsky who represented the consumer said that she was worried about the increasing numbers of people over 65 who will require care in the 80's. As a person involved in school boards in Nova Scotia she has become aware of decreasing enrolment; she suggested that empty school buildings could be used as community health centers where the nurse could be the point of entry into the health care system.

Among the resolutions passed was one on representation from the RNANS on a planning committee for a regional hospital in Cape Breton; establishing a task force to study mental health facilities in the Cape Breton area and another recommending the use of smoke detectors in all private residences and public buildings in Nova Scotia.

The Task Force on Mandatory Continuing Education as a requirement for RNANS registration presented their report with the recommendation that "continuing education should not be mandatory but a personal responsibility". This resolution was accepted.

Life membership was conferred on Sister Clare Marie Lyons, RNANS education consultant who has spent 41 years in nursing education in Nova Scotia, 31 as a teacher and the last ten years with the RNANS. She received many tributes and a standing ovation. ❖



## Canadian nurses to write CGFNS examinations

Legislation requiring all foreign nurse graduates, including Canadians, seeking a non-immigrant occupational preference visa that will enable them to practice in the US to pass the Commission on Graduates of Foreign Nursing Schools (CGFNS) Qualifying Examination became effective May 16 this year.

Warning of the new rule was contained in the January issue of the *Canadian Nurse*. The rule affects all foreign nurse graduates who have not already obtained a full and unrestricted licence to practice professional nursing in the state of intended employment. Three cities in Canada and five in the US are among the 36 test centers selected for the next examination, October 1, 1980. The Canadian sites are Montreal, Toronto and Vancouver. Filing deadline for the October exam was July 14.

In addition, the US Department of Labor (DOL) has issued a proposed new rule requiring FNGs to pass the CGFNS examination if they seek a labor certificate in order to obtain a third or sixth occupational preference visa. In a step preceding the DOL rule's enactment, this proposal was published in the *Federal Register* on January 22, 1980. Final publication and enactment of this new rule is expected in the near future.

Jessie Scott, newly-elected President of CGFNS' Board of Trustees, points out that the latest statistics show CGFNS is achieving the purposes for which it was established. Of those FNGs who have taken and passed the CGFNS exam, come to the US and taken the state licensing exam (SBTPE), 80 per cent have passed the SBTPE and hold a license to practice as a registered nurse. This contrasts sharply with the fact that in recent years, only about 20 per cent of foreign nurses passed the state licensing exam.

"The CGFNS examination, which determines the nurses' ability to pass the state licensing examination before they come to the United States, helps protect

foreign nurses who are not prepared for professional practice in this country against relocation costs, personal disappointment, and possible exploitation," according to president Scott, "and at the same time, it helps assure the American health care consumer of minimum safe practices."

CGFNS is sponsored by the American Nurses' Association and the National League for Nursing and is presently operating under a grant from the Kellogg Foundation.

## National OR meeting draws 1100 nurses

"We judge ourselves by our intentions but we evaluate our boss and she evaluates us by our actions." Harvey Silver, freelance management consultant in Organizational Psychology, spoke on the topic of performance appraisal (PA) at the sixth national Operating Room Nurses Conference in Toronto, April 28-May 1.

"A person is a process, not a product; it is never game over, he can change, modify, grow and become in a constant developing process." With this in mind, Dr. Silver suggested that since it is behaviors and not personalities which are being evaluated in a performance appraisal, the supervisor and employee should attempt to look at the appraised behavior from a distance, as

an "it", so that vested interests no longer play a part. The PA should focus on three items: what behaviors should be continued, what behaviors should be initiated and what behaviors should be stopped. By recognizing that the goal of PA is not perfectionism, but progress, and that usually it is a person's attitude rather than her aptitude which determines her success on the job, then "inch by inch, anything is a cinch".

More than 1100 registrants from across Canada and the United States, attended the conference which was hosted by the Operating Room Nurses of Greater Toronto. The conference theme was "Changes, Challenges and Choices of the 1980's." Speakers who addressed this theme included Patricia Leblanc, RN, Hamilton General Hospital and Faye Trouten, RN, BScN, Hospital for Sick Children, Toronto and Pat Williams, RN, Women's College Hospital, Toronto.

Working with invasive pressure monitoring, understanding how transducers, amplifiers, demodulators, peak detectors, meters and oscilloscopes function was the topic of a presentation by Catherine Boileau, RN, BScN, assistant coordinator of educational services, Humber Memorial Hospital, Toronto. She pointed out that since nurses often have input into the types of equipment that their units purchase they should make themselves knowledgeable of what is on

the market and how it functions, so that they can ensure that they have the best equipment to work with, will know how to use it properly and understand the meanings of readings they obtain.

Plans are already underway for the seventh National Conference for Operating Room Nurses to be held two years from now in Winnipeg, Manitoba. For more information contact: Fran Fenton, c/o Operating Room, St. Boniface General Hospital, Winnipeg, Manitoba.

## Dalhousie launches R & D campaign

A three-year campaign for research and development funds has been launched by Dalhousie University School of Nursing to stimulate and support nursing research in the Atlantic provinces.

A target of \$150,000 has been set and the first major contribution to the fund, a \$2,500 donation from the Registered Nurses Association of Nova Scotia, has already been received.

Professor Margaret Bradley, acting director of the school of nursing, commenting on the campaign, said that "nursing research is in its infancy in this part of Canada, and indeed elsewhere" and noted that the idea for the campaign originated with a faculty member who encountered difficulty in obtaining funds to support her research. ♣



Plans are underway for the seventh national conference on nursing research. The conference, to be held in Halifax between October 22 and 24, is

a first for the Atlantic region. Above from left are co-ordinators Barbara Devine, Ruth MacKay, Evelyn Pollard and Marion Allen.



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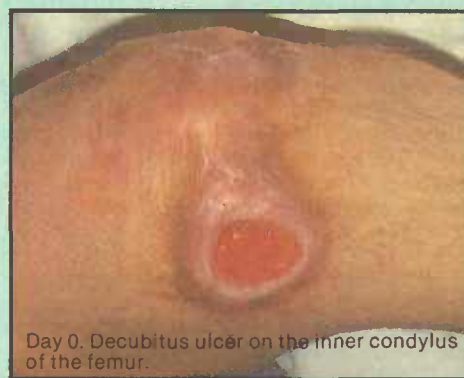


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1. Winter, G.D.: Healing of Skin Wounds and the Influence of Dressings on the Repair Process—Surgical Dressings and Wound Healing, Harkiss, K.J. (Ed.), Bradford University Press, 1971.

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## YOU AND THE LAW

### The responsibility of the patient

Corinne Sklar

Recently some friends who are nurses were discussing negligence and the delivery of patient care. Mindful of their legal responsibility to the patient they asked: "What about the patient? Doesn't the patient have some responsibility in all of this? What about the patient who fails to follow instructions, refuses recommended treatment or does not return for follow-up?"

As a general rule, the patient *does* have the right to refuse treatment. This right of refusal can be exercised by the patient at any point during the course of treatment. The patient also has the right to refuse to seek treatment, to decide to change physicians, to stop taking his medication or to delay obtaining further or any medical advice. Patients often discharge themselves from hospital AMA (against medical advice). While this may be frustrating and discouraging to health care providers, nevertheless this remains the right of the patient.

The right to determine what shall be done to his body is a right of the adult person of sound mind; it is the cornerstone of the law regarding consent to medical treatment since the application of health care without the consent of the patient results in the commission of the legal wrong of battery.

The patient's right to choose includes the right to make decisions about his own health that may be inconsistent with the view of those providing health care. He may, for example, make a choice that is not in the "best interests" of his health. He cannot be compelled to accede to the viewpoint of physicians or nurses; the final decision rests with him.<sup>2</sup>

Ideally, refusal or rejection of treatment by the patient should be as informed a choice as any consent obtained but this is not always the case. Decisions are based on the internal and external sources and resources of the individual and medical input is only part of this process. People make lifestyle and other personal decisions that directly or indirectly affect their health every day. In general, the law does not impose an affirmative duty upon us to maintain and safeguard our health. For example, vaccination is strongly recommended as a health measure but no law of Canada expressly requires it of the general population, although certain public health or other requirements such as travel to other countries or specific employment may result in the imposition of such treatments upon an individual in order to safeguard the health of others. As a



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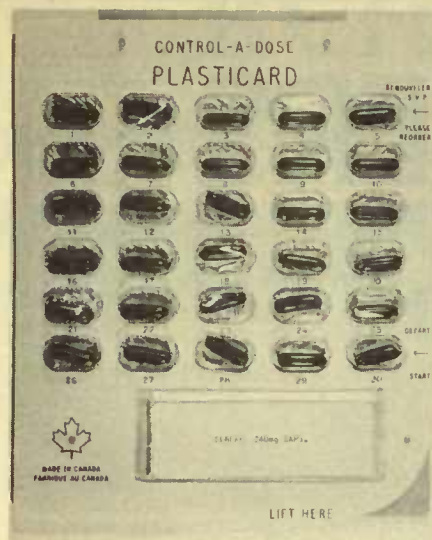
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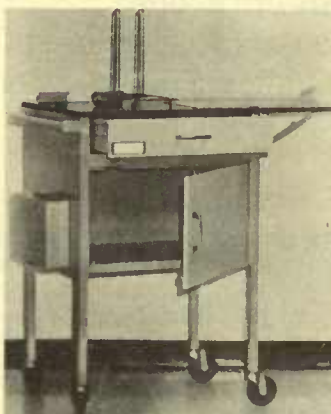
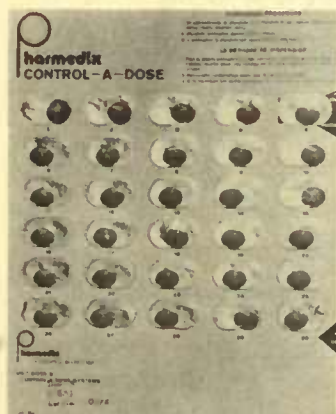
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general rule vaccination for one's own protection, while prudent, is not mandatory. Where there exists no positive duty upon the individual to seek or continue treatment for his own benefit, there is no legal liability imposed upon him for failure to do so.

The responsibility of a patient arises from the law of negligence. Legally, this responsibility may be manifest when the patient complains that those who owed him a duty of care failed in this duty and that this breach of duty resulted in harm (injury, loss, damage) for which he now comes before the Court requesting legal redress. Thus, in defence of a claim by a patient of malpractice against a physician, a nurse, a hospital (individually or in any combination), the issue may be raised of the patient's having contributed to the harm of which he complains.

For any complaint of negligence to succeed in Court, the complainant must prove that the defendant (the person whose conduct is in issue) owed him a duty in law (that is, a legal responsibility of care) and that the defendant breached that duty. The plaintiff (ie. complainant) must show that the harm he suffered was the result of that inferior conduct and was reasonably foreseeable. In addition, the plaintiff must not have done anything to have caused or aggravated the harm he suffered. It is this area which may provide a fruitful defence and which gives rise to the patient's duty to himself.

Conduct which contributes to the harm of which the patient complains is called "contributory negligence". In the past, a finding by the Court that the plaintiff had been contributorily negligent resulted in loss of the entire suit whether or not the defendant had breached his duty and caused him harm. Such a harsh result is not possible under today's law.

If the defence proves to the Court that the harm to the patient was not caused by the defendant but was caused solely by the patient's conduct, then the plaintiff/patient will lose his lawsuit. The harm of which the patient complained must have resulted solely from his own conduct; the patient was the author of his own misfortune. Where it can be proven that the patient's conduct alone caused his harm, then the defendant is absolved of legal liability, notwithstanding the fact that the defendant's conduct fell below the standard of care required in the circumstances. Before legal liability can be imposed upon the defendant, the plaintiff must convince the Court that the defendant's conduct caused him harm. If the harm is not the result of the defendant's conduct even if it was negligent, then the defendant is not legally responsible for it. Such an answer and finding can be considered a total defence to the plaintiff's claim against the defendant.

More often it can be established that the defendant's conduct did result in the harm of which the patient complains. In this situation it may be



open to the defendant to attempt to convince the Court in his defence that his fault in the matter is diminished because the patient contributed to his injury through his own conduct and he therefore was contributorily negligent.

The standard of care expected of the physician or nurse is that of the reasonable prudent practitioner (or specialist, as the case may be) with similar training and experience. The standard of care by which the patient's conduct is measured is that of a reasonable, prudent patient in similar circumstances. The standards applied are objective standards. Conduct which does not meet these objective yardsticks is deemed to be negligent.

Once it is established that the harm resulted from negligence on both sides, then it falls to the Court to determine in what degree each is responsible. All of the provinces of Canada have in force legislation which permits a Court to apportion the degree of fault or legal responsibility between the parties. For example, the trial judge may decide on the evidence presented to the Court that the patient was five, 20, 50 or 75 per cent to blame for his own harm. The damages awarded to the plaintiff will be reduced by the degree of fault ascribed to him. Therefore, if the trial judge finds that the measure of damages for any injury is \$10,000 but believes that the patient was 30 per cent and the physician was 70 per cent to blame, the patient will recover only \$7,000 from the physician. The patient's recovery is reduced by the percentage of fault found against him.

In the U.S. many states retain the requirement that the patient, in order to recover damages, must be free of any contributory negligence. There are a few Canadian cases, however, in which a claim against providers of health care has raised the issue of contributory negligence on the part of the patient.

The most recent Canadian case is that of *Crossman v. Stewart*.<sup>3</sup> Mrs. Crossman was referred to the defendant dermatologist for treatment of a facial skin disorder which he diagnosed as discoid lupus erythematosus. He prescribed Aralen® (generically, chloroquine) tablets 250 mgm, one or two tablets to be taken daily. The dermatologist saw the patient for consultation and treatment six times in the six months between January 16 and June 16, 1962; he gave her prescriptions for the medication on all but one of these visits. The patient obtained the medication from a pharmacy and found that it was effective. Between June 1962 and January 1963 the patient did not see the defendant but continued to take the drug which she obtained without a prescription from a drug salesman who sold drugs to the physician for whom the patient worked as a medical receptionist. The Court found that the defendant was not aware of nor did he approve of this method of obtaining the drug.<sup>4</sup>

In December 1962 the defendant attended a medical convention where he

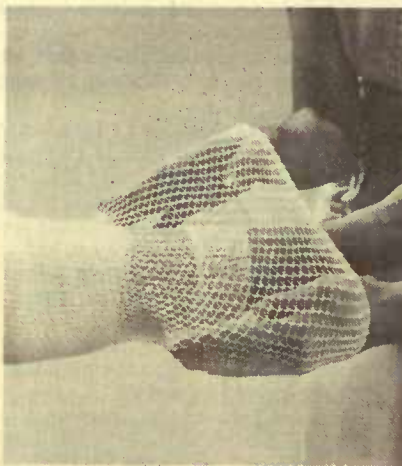
learned that some patients, as a result of prolonged use of the drug, had suffered irreversible damage to the retina causing blindness. Already aware that there were risks associated with long term use of the drug, and alerted now to this specific danger, he called in all of his patients who had been so treated and arranged for them to have their eyes examined by an ophthalmologist. Mrs. Crossman was called in on January 28, 1963. The specialist's report,<sup>5</sup> dated February 14, 1963, indicated that while there was no evidence of retinopathy, there were some corneal changes suggestive of a sequelae of chloroquine therapy. The report stated that Mrs. Crossman gave

a history of having had the medication for the past 13-14 months. Mrs. Crossman was not warned at any time of the dangers of prolonged use of the drug. The defendant was never informed that the patient continued to use the drug.

Although the patient was seen by the defendant several times in early 1963, no more medication was prescribed. From March 1963 to March 1965, the patient did not see the defendant but continued to take the drug, again obtaining her supply from the drug salesman. This supply route terminated in the summer of 1964 when the salesman retired.

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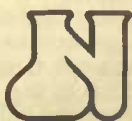
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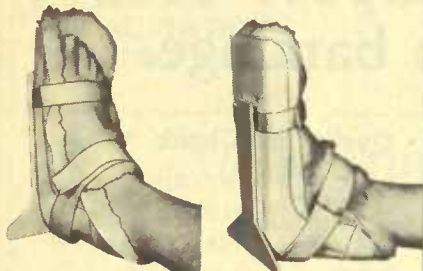


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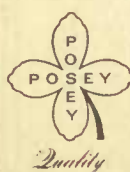
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In March 1965, the defendant was again consulted by Mrs. Crossman and he again prescribed Aralen therapy which continued until the fall of 1965. The last prescription was dated September, 1965.

In April of 1966, signs of retinal damage were found and it was determined that permanent irreversible retinal damage had occurred. By 1971, Mrs. Crossman's vision was so impaired that she could no longer work. At the date of trial she was "near" blind. Mrs. Crossman can see large objects within a few feet of her but she cannot read or sew. To go out, she requires someone to guide her. She does her housework and cooking by a sense of touch.<sup>6</sup>

The trial judge found liability on the part of the physician and fault on the part of the patient. He found that the physician had breached the required standard of care when he failed to discover the consumption of the drug by the patient over a prolonged period; a careful review of the specialist's report in February 1963 would have disclosed this. The trial judge specifically stated that a higher standard of care must be met where the drug being used may cause permanent substantial damage. In addition, a careful review of the report would have alerted the defendant to the patient's ingestion of the drug long after he had last prescribed it because of the corneal changes reported by the specialist. Corneal changes are reversible upon cessation of the drug therapy; retinal changes demonstrate permanent damage.

The trial judge found that Mrs. Crossman was two thirds responsible. He said:<sup>7</sup>

"...While a reasonable patient is not required to possess special knowledge related to the specific risks involved in using "prescription" drugs, it seems to me that ordinary commonsense would dictate that it is foolhardy in the extreme to do the following things: (a) to obtain "prescription" drugs from an unorthodox source. (b) to continue to use drugs on a prolonged basis without obtaining "prescription" renewals. (c) to continue to use drugs on a prolonged basis without consulting the "prescribing" physician (in this case almost two years).

Surely the "reasonable patient" knows fully well that a pharmacist will not renew a prescription without obtaining at least a "telephone" authorization from the prescribing physician. Surely he knows that the reason for such cautious behavior on the part of pharmacists is because of the real dangers involved in the use of "prescription" drugs in an unauthorized manner."

In the view of the trial judge, if the patient had acted with any reasonable degree of prudence, permanent eye damage would have been averted. He assessed damages at \$80,000, apportioning fault one third to the defendant and two thirds to the patient. Mrs. Crossman recovered only

one third of the total \$80,000 damages.

Remember that the patient has the responsibility of acting reasonably in the circumstances: he cannot cast blame on those delivering health care without assuming some responsibility for his own conduct. While duties of affirmative action have not been specifically imposed, some writers are of the view that a finding of contributory negligence could result where the patient fails

- to return for treatment
- to seek treatment
- to cooperate during treatment or
- to follow instructions.<sup>8</sup>

Further, a failure to disclose personal information in response to the health provider's questions might also result in such a finding. Future cases will determine such results.

Health care providers continue to have a legal responsibility to meet the required standard of care. In order to protect themselves and/or the health care facility, appropriate communication with the patient and recording of instructions is prudent. In the Crossman case, the detailed notes made by the defendant helped him to substantiate his evidence regarding his practice and his recollection of the facts.

Nurses should record specific warnings given to patients, for example, not to get out of bed, not to eat or drink anything or specific foods. Where incidents occur as a result of the patient's failure to follow instructions (for example, the patient fell when she failed to call for assistance in getting out of bed), nurses should record the salient facts at that time. If a patient is to return for follow-up treatment, it is important to communicate this clearly to him, explaining why and recording the communication.

The law does not demand perfection from doctors, nurses and hospitals, nor from patients: what is required is reasonable and prudent conduct in the circumstances. Meeting this standard will help to avoid findings of direct or contributory negligence. 4

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- 2 —. Was the patient informed? *Canad. Nurse*, 76(6):18-22, passim; 1980 Jun. The right of the adult patient of sound mind is considered here. Other considerations come into play when the patient is a minor or suffers from mental incapacity. These special circumstances are beyond the scope of this column.
- 3 \*(1978) 82 D.L.R. (3d) 677 (B.C.S.C.)
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\*Not verified

"You and the law" is a regular column that appears each month in *The Canadian Nurse* and *L'infirmière canadienne*. Author Corinne L. Sklar is a recent graduate of the University of Toronto Faculty of Law. Prior to entering law school, she obtained her BScN and MS degrees in nursing from the University of Toronto and University of Michigan.



# SPOTLIGHT ON AGING

"In nursing school, I was taught that disorientation was a result of poor nursing care. So when I took care of patients, I did not document how disoriented they were, but how 'clear' they were. To do otherwise would have been to show my teacher the poor quality of my nursing care. With this expectation I discovered it was possible to talk to patients clearly even when they were disoriented, and that there were meaningful thoughts behind their disorientation." (Loretta Nowakowski "Disorientation-signal or diagnosis", Journ.Geron.Nsg. Vol. 5, No. 4, April 1980) As nurses, are our attitudes towards aging based on reality, or are they largely determined by negative stereotypes and false or misleading information? Isn't aging a normal part of human development? Will you live out your negative fantasies, even if there is a way out?

## PART ONE

# A self-help guide to the aging process

Patricia Morden



## To use the chart

This chart has been prepared so that it may be used as either a learning tool or an information package for groups or individuals.

If you decide to use it as a *learning package*, all you have to do is, first, read through the sections on normal physiological changes and some of the accompanying pathophysiological occurrences and circumstantial factors, that may accentuate the aging process, then cover the right hand column and see how many nursing measures or observations you can think of to alleviate existing or potential problems.

As a *learning resource*, the chart can be displayed on a handy bulletin board or filed for review, with the option always of adding your own ideas to the suggestions it contains.

Either way, we hope it provokes personal and professional thought and discussion, since it is only by continual review of what we are doing and why that we can continue to plan for and provide responsive, caring health services for the over-65's in our midst.

# 1

## MENTAL STATUS

While no age-related changes in verbal ability have been recognized, the following may be noted:

- general decline in psychomotor skills (general CNS as well as special senses),
- increasing susceptibility to interference in problem solving,
- more time is required to process information,
- amount and accuracy of sensory input is decreased.

Mental confusion may be due to a change in environment, decreased sensory stimulation, medications, fear or anxiety, decreased O<sub>2</sub>, electrolyte imbalances, poor nutrition, psychotic illness, sub-dural hematoma, depression or disease states such as hypo/hyperthyroidism, hypo/hyperglycemia, myocardial infarction or infection which often presents as confusion before the temperature is elevated.

*Many potentially curable conditions present with symptoms that are easily mistaken for confusion. Determination of your patient's mental status requires careful assessment. Where should you begin?*

1. Modern tests of intelligence and mental ability may disadvantage the elderly person in many ways as their education, values and interests may be quite different from those tested. Give the individual time to think and answer questions. Many tests are time limited and do not allow for accurate assessment of the mental status.
2. There is a need for assessment and re-assessment of treatment modalities such as reality orientation, re-socialization etc. More consideration must be given to psychotherapeutic modalities for elderly persons.
3. We must begin by examining our own attitudes and values re: aging, the aged person and how this affects our interaction with them.
- 4.
- 5.



## 2

### VISION

With the normal aging process the following changes may occur:

- **presbyopia**, the crystalline lens loses the ability to adapt its shape and results in a decrease in peripheral vision and some degree of myopia,
- **atrophy and rigidity of the iris** causing a decrease in pupil size, leading to decreasing ability to adapt to changes in light,
- **arcus senilis**, a clouded ring may form around the cornea,
- **retinal atrophy** causing a decreased capacity to distinguish color and brightness, (especially in the blue-green range),
- **reaction time may increase**, especially with a rapid series of visual stimuli.

Two common conditions that frequently occur in this age group are glaucoma and senile cataracts.

*Knowing this, how many nursing measures or observations can you suggest to ease the visual problems encountered by the aging person?*

1. Ensure preventive screening tests for glaucoma and cataracts are done.
2. Ensure each individual wears and has access to his glasses as required.
3. Remember, focusing on close objects, including a face that may be too close, may be difficult.
4. Elderly persons sitting in rows may be unaware of anyone beside them because of decreased peripheral vision.
5. Leave a light on in hallways and bathrooms at night.
6. Decrease of color vision may affect clothing choices and the effect of the environment on the person's mood.
7. Contrasting strips of color on steps, around doorways and on toilet seats make them easier to distinguish from their surroundings.
8. Be aware of the confusing effect of glare on vision, e.g. shiny floors.
9. Consider nametags with yellow backgrounds and black block letters as yellow is better visually than white.
10. Use large print on prescription bottles and instruction sheets.
- 11.
- 12.

## 3

### HEARING

Loss of hearing may be related to previous middle ear disease, vascular disease or exposure to noise. Presbycusis, degenerative changes in the middle and inner ear, may be associated with such functional abnormalities as:

- **impaired sensitivity** due to tissue atrophy, decrease in the number of hairs in the ear and a decrease in nervous conduction especially at the upper end of the auditory scale, e.g. sounds such as s, sh, and ch,
- **difficulty in sound localization**,
- **decline in sound discrimination**, especially speech.

These functional abnormalities may be exaggerated by a build-up of wax in the ears, ossification of the bones of the middle ear and decreased stimulation especially when institutionalized.

*How can you help an elderly person to cope with these problems?*

1. Lower the pitch of your voice when speaking to someone with high frequency loss, possibly also increase the volume (sometimes when you increase the volume, the pitch will also increase, thus making it even harder for someone to hear).
2. Speak directly to the person, use their name.
3. Speak slowly and clearly.
4. Remember that people who are hard of hearing may withdraw socially as the effort of maintaining involvement in a conversation may be too much work.
5. Be sure that hearing aid batteries are fresh and the hearing aid is positioned correctly.
6. Be aware that persons who do not hear normally may hear some distorted sounds or words and this may cause them to appear confused or even paranoid.
7. Remember that there may not be enough background noise in an institution to keep the hearing sense stimulated. Research on sensory deprivation has shown that in this situation, a person may create his own stimulation and hallucinate.
- 8.
- 9.



## 4

### OLFACTION AND TASTE

As an individual grows older, the following changes may occur:

- the number of nasal hairs decreases,
- receptors atrophy,
- taste buds atrophy and decrease in number,
- oral secretions decrease.

These common effects of aging may be further aggravated by:

- loss of teeth due to poor hygiene
- long term smoking which may cause a decrease in taste sensation
- loose or ill-fitting dentures which may cause problems in mastication and
- the long term effects of institutionalization which may cause decreased stimulation of both taste and smell.

*Can you suggest some measures to alleviate these problems?*

1. Focus on prevention throughout life, through good nutrition, hygiene, mouth and denture care.
2. Teach the use of spices in food preparation, especially for those on sodium-restricted diets.
3. Consider safety carefully — could this elderly person smell smoke if there was a fire?
4. Are there some normal stimuli that you could provide in your work setting, such as brewing coffee?
- 5.
- 6.

## 5

### TOUCH

Receptor sensitivity decreases with age.

The sensation of touch may also be reduced as a result of:

- peripheral neuropathies due to COPD, chronic nutritional deficiencies, anemia, ASHD, etc.
- decreased stimulation due to long term institutionalization and hypothermia.

*How does one determine if tactile sense is reduced and how can you stimulate this sensation?*

1. Assess for chronic medical conditions and peripheral problems.
2. Assess ability to feel hot and cold.
3. Stimulate the tactile sense through finger foods, handicrafts, etc.
- 4.
- 5.

## 6

### SKIN INTEGUMENT

With the normal aging process, there is:

- a decrease in natural moisture and elasticity,
- a decrease in collagen,
- a loss of sub-cutaneous fat in the periphery,
- shrinkage of the epithelial layer of skin,
- a decreased number of sweat glands,
- decreased melanocytes (pigment),
- a decrease in total body hair,
- graying of hair due to loss or malfunction of pigment cells and
- increased facial hair in women due to changes in androgen/estrogen ratio.

A common condition that frequently occurs in this age group is *lentigo senilis* (liverspots), caused by excessive exposure to the sun.

*How do these changes affect nursing care of the elderly?*

1. Decreased sub-cutaneous fat and decreased sensory perception combined with immobility increase the need for nursing intervention. Observe for signs of rubbing of prosthetic devices and encourage or help an individual to change his position in bed and when sitting.
2. Maintain adequate fluid intake. Use super-fatted soaps.
3. The elderly may have more difficulty regulating body temperature due to loss of sweat glands.
4. Preventive sun protection throughout life can help prevent some wrinkles.
5. All these changes can lead to body image problems which can be minimized with good hygiene, make-up, etc.
- 6.
- 7.



# 7

## ENDOCRINE SYSTEM

With the aging process, there is:

- a **generalized decrease in the ability to adapt to stress**,
- a **decrease in the metabolic rate** and
- a **decrease in the functional ability of the thyroid**.

Two common conditions that frequently occur in this age group are maturity onset diabetes and hypo or hyperthyroidism.

*What implications does this system alteration have for nurses?*

1. Thyroid function tests should be included as part of any screening for causes of decreased mental status.
2. Observe for signs of diabetes and through teaching help the elderly person to cope with this condition if it is diagnosed.
- 3.
- 4.

# 8

## GENITOURINARY SYSTEM

(i) Urinary Tract:

This system may undergo the following changes:

- **generalized neurological loss** leading to less conscious inhibition of micturition and thus allowing the spinal reflex to predominate,
- **decreased bladder capacity** due to muscle atrophy,
- **less time between urge to void and need to void**; research has shown that the maximum distance that many people can travel without an accident is 40 feet,
- **decreased urine concentrating ability** of the kidney,
- **decrease in activity** and changes in the cardio-vascular status may also affect this system.

Two complications that may arise are drug toxicity as the kidneys are functioning less efficiently and incontinence, the passing of urine in the wrong place at the wrong time, due to:

- increased pressure on the bladder arising from constipation, a prolapsed uterus or prostatic hypertrophy
- decreased fluid intake which may reduce stimulation of the bladder for voiding reflex
- decreased fluid intake which may cause a decrease in the circulating blood volume and blood pressure which may lead to some confusion and weakness and then incontinence
- medications, specifically those which sedate or increase urgency or urine volume
- restraining, with restraints, drugs or even furniture that is difficult to get out of
- change in environment
- immobility
- illness
- retention which may lead to overflow
- dribbling
- urinary tract infection
- psychological problems
- decreased mental functioning, and
- lack of privacy or other environmental issues.

**Remember that continence is a conditioned response, one thing that keeps us continent is our clothing.**

**It is very easy for incontinence to become the conditioned response.**

*What problems should you be aware of and how can nurses best cope with incontinence?*

1. Assess carefully the causes of incontinence.
2. Take a detailed and complete incontinence history.
3. Remember restlessness in a patient who has difficulty communicating may indicate a need to void.
4. Reducing fluid intake may increase the problem of incontinence rather than solve it.
5. Blood flow to the kidneys may increase at night due to the recumbent position, thus increasing the production of urine.
6. Remember to leave lights on in bathrooms and provide a safe, easy access.
7. Incontinence may be a conditioned response to the preference of remaining in the comfortable privacy of bed rather than attempting to urinate in a room with other people or while someone waits in the bathroom with him.
8. Wearing street clothes with underwear may be a strong social stimulus for continence.
9. Mark toilets well, ensure that persons who need assistance have a call bell at all times, even when sitting in the corridor or in the sunroom.
10. Pelvic floor exercises may be useful to prevent and stop problems with dribbling in both men and women.
11. Be aware of drugs metabolized in the kidney and recognize signs of their toxicity.
12. Be aware of new products and make manufacturers aware of your needs.
13. As there are often many incontinent patients on one floor and it will take much initial effort to re-train some people, it is important to choose only one or two at a time so that you can give the time and effort necessary for success.
- 14.
- 15.



## (ii) Sexuality:

With aging, males experience:

- an increased need for stimulation, both direct penile stimulation and psychological stimulation,
- an increased refractory period between erections,
- a decreased ejaculatory force.

Women will note the following changes:

- decreased vaginal lubrication,
- decreased orgasmic intensity,
- increased libido with hormonal changes post-menopause, or difficulties with sexual response due to lack of or infrequent sexual intercourse.

Sexuality may be also influenced by social norms and attitudes: "people over 60 shouldn't"; the increased response time may cause some men to give up in frustration; widowhood may lead to difficulties in finding partners, and sexuality may decrease as a result of a negative response or poor psychological adjustment to changes in body image and sexual response.

1. Counseling often helps this group to understand age-related changes in sexual responsiveness and determine how they can best meet their personal needs. Counselors must be careful not to suggest their own values if the elderly person is satisfied with his/her situation.
2. Provide privacy in institutions.
- 3.
- 4.

*How can nurses best help the elderly to cope with their sexuality?*

## CARDIOVASCULAR SYSTEM

Changes in this system usually result in changes in the respiratory system, and vice versa. Basically, changes in the heart and vessels that are related to aging are functional changes which reduce the heart's ability to adapt to excessive stress. The changes normally attributed to aging include:

- atherosclerosis, which is usually present after the second decade of an individual's life,
- decreased collagen, leading to decreased elasticity of arteries,
- changes in heart size,
- decreased heart rate with irregular beats due to loss of some resiliency of the heart muscle,
- a decreased resting cardiac output which decreases as much as 30-40 per cent between ages 25 and 65,
- thickened valves due to sclerosis and fibrosis,
- increased blood pressure which is necessary for physiological functioning due to the decreased elasticity of the vessels and the increased lability of vaso-pressor control.

Conditions which may further aggravate these effects of aging include myocardial infarction, congestive heart failure, cardiovascular accident, angina hypertension, murmurs due to malfunctioning valves, and hypotension due to dehydration, medications, postural changes, inactivity and peripheral pooling of body fluids.

*What nursing measures should be considered in caring for patients who may be suffering from any of these functional changes or complications?*

1. Assess the need for medications carefully — consider the ranges of blood pressure to determine what is functional and what is pathological.
2. Confusion may be a result of low cardiac output.
3. Lack of exercise, excessive food and alcohol intake, and smoking may all cause problems.
4. Management of heart disease must include consideration of all other systems, e.g. a decreased glomerular filtration rate may lead to drug toxicity at "normal" dosages.
5. Preventive counseling on nutrition, exercise, smoking, etc. should take place throughout life.
6. Assess medications being taken, compliance and the patient's understanding of drug.
7. Positional changes and exercise are necessary to decrease peripheral pooling, hypotension, etc.
- 8.
- 9.



# 10

## RESPIRATORY SYSTEM

As an individual ages these changes take place:

- **decreased collagen** leads to decreased elasticity of the lungs, decreased efficiency of the smaller bronchioles and a decrease in chest wall compliancy,
- **decreased perfusion** due to atherosclerosis,
- **decreased gas transfer** due to a loss of lung capillaries with age,
- **decreased ciliary action** due to decrease in epithelial layer and moisture.

Smoking, emphysema, congestive heart failure and the immobility often promoted with bed rest aggravate the above effects of aging.

*What factors are important in coping with these changes?*

1. Respiratory infections can become increasingly more dangerous as lung and chest resiliency decreases.
2. Optimal positioning must be ensured for best lung perfusion.
3. Confusion may be caused by lack of O<sub>2</sub>. Respiratory infections may be indicated by confusion rather than elevated temperatures.
4. Environmental pollution must be considered in promoting respiratory health and in its effect on an already compromised system.
- 5.
- 6.

# 11

## GASTRO-INTESTINAL SYSTEM AND NUTRITION

(i) Intake may be affected by:

- **changes in taste and smell,**
- **decreased caloric requirements** due to decreased activity and a decreased metabolic rate,
- **digestion problems** resulting from atrophic changes in the gastric mucosa causing decreased gastric secretions,
- **impaired intestinal absorption** due to mucosal atrophy and changes,
- **decreased fat absorption,** including fat soluble vitamins due to ptosis of the gall bladder as a result of a decreased elasticity of the walls.

Common contributing factors to nutritional problems include:

- loss of teeth or ill-fitting dentures
- loneliness, eating alone may decrease the appetite
- decreased power of mastication due to teeth loss, dentures and generalized muscle atrophy
- obesity as intake remains constant but activity decreases or losses in life may be dealt with by increasing intake
- chronic illness may decrease the appetite and/or hamper the ability to prepare or shop for food.

*What positive steps can you take to make sure older individuals are eating properly?*

(ii) Output changes are usually related to:

- **a decrease in tone** of the abdominal muscles due to atrophy,
- **a decrease in sensitivity** of the nervous system to stimulation.

These effects of aging may be further affected by:

- decreased dietary bulk due to decreased intake, difficulty with mastication, or restrictive diets
- chronic constipation due to decreased food and/or fluid intake, chronic laxative abuse, medications for other medical conditions, lack of physical activity, diverticular disease, hiatus hernia, cancer of the colon, or depression
- dehydration from many causes such as lack of availability or reducing fluid intake due to fear of urinary incontinence.

*What can you do to reduce these bowel problems?*

1. Offer guidance in coping with cooking restrictions, i.e. add spices to low salt diet. A dangerous lack of nutrition and a reduced psychological satisfaction are frequently associated with diet changes.
2. Consider giving budget and nutrition counseling.
3. Assess for chronic vitamin deficiency.
- 4.
- 5.
1. Increase bulk in the diet through the use of bran, whole wheat bread, etc.
2. Assess present diet and fluid intake, include past defecation patterns and laxative use in history.
3. Provide privacy and comfort for defecation.
4. Monitor urine and stools for signs of malabsorption or metabolic deficiencies (mineral oil used as a laxative may cause Vitamin A, D and E deficiencies).
5. If constipation is present, assess for type, then treat the cause and symptoms (some people report lack of a regular bowel movement as constipation, others define it when stools are hard and difficult to pass).
- 6.
- 7.



With increasing age:

- muscle fibers are replaced with scar (fibrous) tissue,
- elastic fibers are mineralized, e.g. ligaments calcify,
- cartilaginous joint surfaces are eroded and ossification follows,
- soft tissue in joints degenerates,
- ligaments of vertebrae calcify and ossificate,
- intervertebral discs atrophy, and
- osteoporosis is generalized.

The most common condition associated with this group is arthritis.

*How can you protect and prolong the mobility of your aging patient?*

1. Bones are generally less able to withstand stress, for example, there are changes in the angle of the neck of the femur and the shaft.
2. Joint mobility can be maintained through exercise.
3. Chairs with arms make it easier for these individuals to be mobile.
4. Rehabilitation time is increased.
- 5.
- 6.

#### Resources for the Older Canadian

a) *"Don't Take it Easy"* is a motivational 40-page booklet designed to give those over the age of 55, some practical information about physical activity and its relationship to health, aging and well-being.

*"Take It Easy...But Take It"* the companion booklet, is an illustrated home exercise program designed to be safe and effective for the mobile senior adult.

Single copies of both booklets are available free of charge upon request; sets of up to 40 copies may be obtained by health and fitness professionals, leaders of group fitness classes or pre-retirement courses.

b) *Health and Fitness* is a 60-page comprehensive booklet of fitness.

c) *General information*, pamphlets and posters on fitness.

Write to: *Fitness Canada, Journal Building, 365 Laurier Ave. W., 11th Floor, Ottawa, Ontario K1A 0M5.*

d) *The Fit Kit* contains the Canadian Home Fitness Test, a Fitness Progress Chart and Fit-Tip Exercises (Cost \$7.95).

Write to: *Fit-Kit, P.O. Box 5100, Thornhill, Ontario L3T 4S5.*

e) *Canada food guide*, information, pamphlets or posters on nutrition, alcohol, drugs or tobacco.

Write to: *Health Promotion Directorate, Health Services and Promotion Branch, Department of National Health and Welfare, Ottawa, Ontario K1A 1B4.*

f) *Funding* is available for community-based projects in Fitness and Recreation for retired adults.

Write to: *National Office, New Horizon Programs, Health and Welfare Canada, Ottawa, Ontario K1A 1B5.*

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Pat Morden, a graduate of the School of Nursing, McMaster University, is currently completing her M.Ed. degree at the Ontario Institute for Studies in Education while lecturing part time at the School of Nursing, McMaster University. Her previous experience includes working as a nurse clinician in a chronic hospital.



# Reality Orientation: Establishing a climate of trust in geriatric care

Marion Walker Rosalie Nepom



*Mrs. Turner is 84 years old. Every afternoon as the sun sinks lower in the sky and dusk approaches, the nurses who have been with her all day gather their things and prepare to leave. New faces, rested and fresh, appear off the elevator and slowly, the fear builds as old anxieties stir inside Mrs. Turner. In days gone by this was the time when she awaited the return of her husband from work, this was the time to worry about the little ones getting safely back from school and it was the time to start dinner for her family, which she forgets has now grown and established lives of their own. Every afternoon when she becomes afraid, she paces and wrings her hands and starts to cry; her look is one of utmost worry and suffering.*

*But every afternoon a wonderful thing happens for Mrs. Turner. The nurses aide assigned to her that day always finds her, takes her hand, looks into her sorrowful face and says, "It's OK Mrs. Turner, you will be safe with us here in your home for the night; we will cook your dinner and show you where the dining room is when it's time to eat, and we will help you to your room when it's time to go to bed. Here is your evening nurse. I am going home now but she will be with you for the whole evening. Goodbye, I'll see you tomorrow." Then the evening nurses aide takes her hand and says, "I am here to take care of you. Come let's go down to the lounge and sit together for a few minutes."*

*Every day the worried look begins to fade as Mrs. Turner realizes that she is still with people she can trust and that for at least one more day everything will be alright.*

What we have just described is the miracle which we observe every day at the Jewish Home for the Aged, Baycrest Centre in Toronto, where our residents reflect the kindness, concern and consistency of the reality orientation program that is now a well established part of their care. For Mrs. Turner, now into her fifth year as a resident of our Special Care Section, reality orientation has helped her to cope with her organic brain disease, a disease which has caused her to lose her ability to remember recent events and left her not knowing what time it is, where she is or, sometimes, even who she is.

## Organic Brain Disease

Approximately ten per cent of the population over 65 years of age suffer from some type of brain failure, usually termed organic brain syndrome, senile dementia or, more commonly, senility. Mental confusion, disorientation to time, place and person, emotional lability and apathy may all be signs of this deterioration.

Organic brain syndrome is an organic disorder of the brain tissue in which brain cells are actually damaged or lost. It is not a mental illness which is a functional disorder without brain damage. This syndrome which has no known cause also has no known medical treatment. Dr. Roy Fisher of Sunnybrook Hospital, Toronto, states "Where drugs can be used to relieve some of the agitation associated with this disease, drugs to improve dementia have not as yet been shown to be effective." He refers to reality orientation as one of the only methods of treatment at this time.

## What is reality orientation?

Reality orientation is a tool for aiding the elderly, a therapy for the mentally impaired. To accommodate for the loss of memory, the confusion and the break with reality which mental impairment causes, reality orientation is used to provide a helping environment, a climate of trust and a 24 hour supply of needed information. By surrounding the affected individual, not haphazardly, but 24 hours a day with simple information such as names, time and weather conditions, this stimulation and constant reminder can rebuild confidence, lessen agitation and sometimes even stimulate thought processes back into use.

A person who has suffered memory and orientation loss needs someone in the environment to tell him where he is, what time it is and what he should expect next. For example, when waking in the night, he should be reminded that it is two o'clock in the morning, that he is in bed, that everyone else is sleeping and that you will wake him in time for breakfast. Besides discussing current information, these elderly individuals should be encouraged to socialize, to give their opinions and to verbalize about their past. Interpersonal relationships can be encouraged by emphasizing what another person has said or reinforcing what two individuals have in common.

Although this may seem to be a simple, common sense approach to nursing care which can be learned quickly, it is, on the contrary, extremely difficult for nurses aides who have been primarily trained to give physical care to add this new kind of



repetitive verbal encouragement to their role. However, just knowing that there is something that they can do to help these people who have previously been classified as beyond help, and then actually seeing an improvement in their elderly patients' status can serve as excellent motivation for continuing this approach. Staff can be trained to use the attitudes and concepts needed by the mentally impaired but consistency depends on ongoing supervision and solid nursing administrative support.

### Sharing the experience

In 1978, after working together in geriatrics for ten years, the authors felt that the Special Care approach at Baycrest was something that we wanted to share with other nurses working in similar settings. This feeling was based on two premises: first, this method of dealing with the mentally impaired, which had been developed by the charge nurse of the Special Care Section, *really worked*, and secondly, we both felt that we had absorbed enough of the philosophy and techniques of reality orientation to teach it effectively to others. Also even though we were two very different types of people, we liked each other and felt that as a team, teaching would be fun.

Initially, after organizing our thoughts and putting together a proposal, we contacted one of the local community colleges and were invited to present our ideas to the head of the Workshop Division. To our surprise, he was very skeptical despite our enthusiasm and positive feelings about the potential success of the project. He said that he had never heard of reality orientation and didn't know if this kind of a workshop would sell. When we insisted that there was a great need for teaching in the area of the mentally impaired aged, he reluctantly agreed to prepare a brochure and see what the response to a one day workshop on reality orientation would be.

In late August, 1978, the brochure was circulated. We received over 100 applications for a class capacity of 20. As a result of only one mailing we were able to fill four workshops in that teaching year; in fact, we had to teach classes of 25-27 people when we were actually prepared to work with 20. Now that we knew that the need was as great as we had anticipated, the challenge of presenting our topic was before us. Could we help our students understand the reality of mental impairment and recognize the benefits of reality orientation?

### A learning experience

We have found that the most important factor in teaching reality orientation is to demonstrate what it feels like to be old and so we start our workshop with exercises which simulate the losses of aging. This sensitivity training has proved to be a most effective and dramatic teaching tool. One exercise asks participants to write with the hand they don't normally write with. We give our instructions quickly, without repetition and we limit their time and ask them to hurry. Later, during discussion, a multitude of feelings are expressed, feelings of anger, frustration, futility and helplessness. When this is followed by asking the students what kind of help would have made them feel better, they discover for themselves how a nurse should react in order to be most helpful. The whole experience is then translated from the aged resident experiencing anger and frustration due to loss, to the nurse relating to the resident in the most helpful and welcome way.

During the initial workshops we allocated very little time for discussion or sharing of problems and ideas as we felt that we had much information to give and we could not afford time for discussion. Through trial and error, we found that small discussion task groups with feedback from each group were beneficial, if not essential as each workshop participant came with a different background and differing individual needs. With more open discussion time, fewer questions were left unanswered and more ideas were examined.

Along with a kit, which includes a bibliography as well as selected reprints concerning the evolution and application of reality orientation as a treatment technique, we send our students away with some tips on implementing reality orientation in their work setting. We emphasize the importance of presenting the concept of reality orientation to administration, of obtaining their interest and support before considering instituting this program, as the major change in staff attitudes required by reality orientation cannot be realized without this administrative support. ❖

### Reading list

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Reality orientation therapy was developed by Dr. James C. Folsom of Topeka, Kansas in the late fifties and was first put into practice in 1962 in Mount Pleasant, Iowa.



It seems like yesterday that Mrs. D's kitchen smelled of homemade soup and fresh baked bread. The big dining room table was always noisy and food was plentiful. But things are different now. Cooking only for herself, she's less fussy. Tea and toast will do for dinner. Besides, her dentures hurt when she bites into anything hard and the arthritis in her hands has made cutting meat painful. Carrying groceries three blocks from the store has become too much for her – and the prices are too high anyway.

# Seniors: A target for nutrition education

## PART THREE

Doris Gillis

As people get older, many who have eaten well all their lives slip into careless eating habits. Because the nutrition concerns of the aged are complex and closely interrelated with other medical and social problems, senior citizens are not an easy target for nutrition education. But the potential for improving the nutritional health of the elderly through nutrition education does exist and is gaining recognition.

During the early life of most seniors, diet consisted of simple but nutritious foods, without the highly refined carbohydrate and fat-laden foods popular today. As well, "three-meals-a-day" was everyday fare with breakfast often given a strong emphasis. These food habits are consistent with good nutrition and therefore provide a good background for the elderly to draw upon.

Seniors also have a headstart in nutrition education in that their concern for health generally increases as biological changes of aging appear. They are the most frequent users of health care facilities and are exposed to the expertise of health professionals. Their awareness of the subject is more likely to be increased.

Although much has been written about the nutritional concerns of the elderly, more research into their nutritional requirements is needed.<sup>1</sup> Nutrition problems vary considerably among individuals and are, for the most part, secondary to other physical and social disabilities. Malnutrition, like aging, is progressive and reflects the accumulation of a lifetime of experience (See figure one).

The major nutrition problem of ambulatory, non-institutionalized senior citizens is **obesity**. Nutrition Canada's national nutrition survey tells us that women run a greater risk of becoming obese and that more than one-third of those over 65 years are actually classified as such.<sup>2</sup>

However, energy intakes of seniors surveyed were not excessive; the median intake for women was 1530 kilocalories and for men 2056 kilocalories.<sup>3</sup> This is close to the Canadian Dietary Standard's recommended daily energy intake of 1500 kilocalories for women over 65 years and 2000 kilocalories for senior men.<sup>4</sup> Despite the fact that energy requirements decrease with advancing age due to a decline in both basal metabolism and physical activity, the need for nutrients does not. It was not surprising therefore, to find intakes of protein, iron, vitamin A and calcium of elderly subjects surveyed to be close to or below the acceptable range.

The obvious conclusion therefore is that careful food choice is a must if the senior is to meet nutrient requirements and still maintain energy balance. However, oftentimes physical, social and personal problems can interfere with his diet. Health professionals involved in nutrition education should be aware of such problems in order to effectively deal with each situation (See figure two).

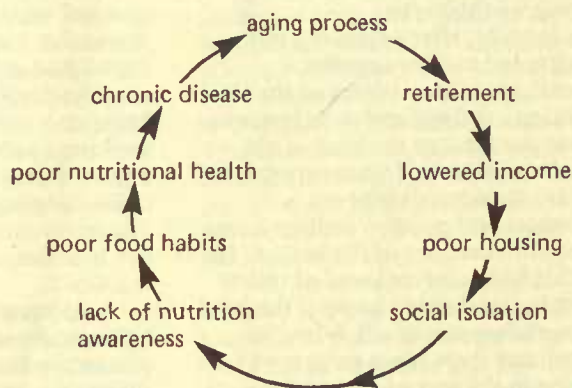
A common physical problem to watch out for is **sensory loss**. A decline in taste and olfactory sensitivity can result in diminished interest in food or in excessive use of salt and sugar to compensate for lack of taste. Hearing and sight impairments can make food shopping difficult, social eating occasions uncomfortable and communication with health professionals limited.

Medical factors such as diabetes, hypertension or cardiovascular disease can limit a person's diet. Although adherence to a special diet can prevent the worsening of such conditions, sometimes several dietary restrictions are recommended without discussing with the senior what he can eat. Indigestion and constipation can cause a senior to avoid fruits, vegetables or whole grain products, and poor fitting dentures can curtail the intake of fibre-rich foods, resulting in increased constipation.

Adaptation to change is difficult in the senior years. Retirement or loss of spouse may necessitate a redefinition in roles of provider, purchaser or preparer of food. To the senior on his own, social isolation may pose the greatest obstacle to sensible eating.

Figure one: The vicious cycle of malnutrition and disease in the aged

(Adapted from "Problems of Nutrition in the aged" by D.B. Rao in Journal of the American Geriatric Society 21:8, page 362, 1973.)



At a time when emotional needs are great, food may be used to excess as a comforting agent, or on the contrary, have limited effectiveness in meeting these needs. Foods which were once a source of pleasure may cause distress in the aged, to the point that dietary restrictions and intolerances become a reminder of the senior's vulnerability to disease and disability.

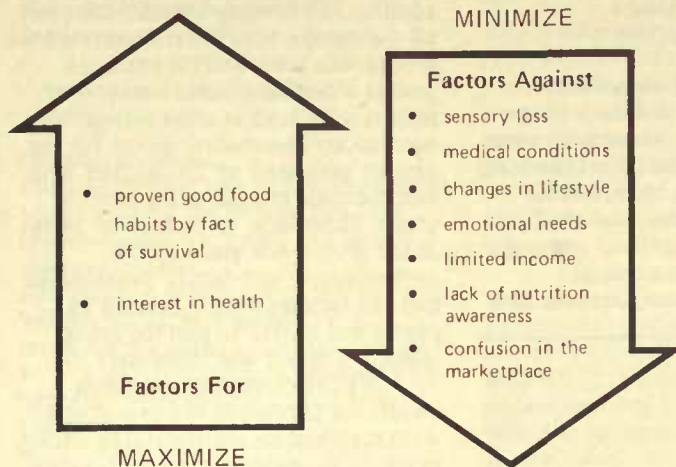
Lower economic status has been shown to have a more adverse effect on the nutritional status of elderly men than women.<sup>5</sup> One might postulate that fewer men than women have the skills and resourcefulness to select nutritious foods on a limited budget, especially if kitchen facilities are minimal or transportation to competitive food stores inconvenient.

The melange of food and non-food products from which to choose may confuse the older consumer, so much so that he neither obtains the product he wants nor makes the most economical and nutritious choice. Distrust of the food supply is not uncommon among seniors.

The senior may not recognize the relationship of sensible eating to good health and feeling good. After all, he may not have a strong appetite, he is no longer growing and he is not as active as in younger days. There may



**Figure two: Role of health professionals in attainment and maintenance of senior's nutritional health**



be a feeling of fatalism in that he does not want to provide nourishment to an aging body. Or, the senior may simply not view nutrition as important. After all, public interest in nutrition is a relatively recent phenomenon. (Most vitamins were not even discovered until after today's seniors had finished their formal schooling!)

Nutrition education programs must be designed to equip seniors with the knowledge and skills necessary to eat sensibly while encouraging them to assume responsibility for their own health. Opportunities to reach senior citizens through nutrition education should be sought and exploited by nurses, as well as other health professions.

In the summer of 1979, a federal government survey<sup>6</sup> of nutrition education programs directed at well Canadian seniors revealed that a variety of approaches have been implemented. Techniques ranged from mass media to individual counseling and from formal lectures to small group discussions. Although further evaluation is needed to identify the most effective means of reaching senior citizens, small group discussions have an obvious advantage in that they provide seniors, themselves, the opportunity to offer each other practical solutions to their problems. The role of the health professional becomes that of facilitating the exchange of a wealth of experiences and skills available within the group, rather than that of providing all the answers.

In attempting to reach seniors with nutrition education, nurses and other health professionals should consider some of the following points:

1. Give seniors the opportunity to define what they want to learn. Needs for nutrition education vary considerably among all individuals, but especially in the senior years, and should be identified before planning the program.
2. Encourage voluntary participation. Adults learn better when willing, and seniors in particular may have short attention spans.
3. Relate nutrition to the senior's life by integrating it with relevant topics (eg. fitness control of medical conditions, personal hygiene) or events (group meals, social functions involving foods, fitness classes).
4. Provide practical information to help seniors deal with the realities of sensible eating. Topics which are frequently identified as concerns by seniors are food budgeting, buying and cooking for one, selecting convenience foods, weight control.
5. Help seniors understand the emotional and social motives for their food selection and eating practices in order to better enable them to make rational food decisions.

6. Respect existing food practices and positively reinforce acceptable food habits. Changing food habits is difficult but not impossible, especially if minor adaptation rather than complete modification is recommended.

7. Emphasize health and "feeling good" as benefits of sensible eating. Good nutrition can enhance quality of life in the senior years.

8. Provide opportunities for the sharing of experiences and knowledge among seniors. Special attention to the dynamics of small group discussion can facilitate exchange of ideas. Visual aids can be particularly effective in stimulating while guiding discussion as well as in holding the senior's attention.

9. Be alert to possible entries into the topic of prevention, both as it relates to senior's food habits as well as the practices of younger family members.

10. Project a positive attitude toward both the process of aging and the senior years. Prevention is hard to sell if the goal is not appealing.

The concern for nutrition education has only recently spilled over into senior years. However, as the older segment of our population expands, it will invariably demand greater attention. By the year 2,000, about 12 per cent of the Canadian population will be over 65 years of age.<sup>7</sup> As the nutrition problems of Canadians tend to become more severe with advancing age, health professionals must direct their attention not only to prevention in early life, but also to prevention throughout later life. ♦

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Self-help groups have increased tremendously in the past 20 years; they are used to supplement and, sometimes, to provide an alternative to traditional professional care. All such groups are based on the "veteran concept": those who have successfully weathered the specific crisis are available to help those new to the situation. Some groups include a role for the professional, others completely reject it; some meet only for the duration of the crisis, others see the group as a possible life-long support.

Staff in neonatal intensive care units (N.I.C.U.) are becoming more concerned with the needs of parents and ways to promote solid parent-infant relationships. Although parents are seen as members of the team caring for the infant, they require special support during this crucial time. This is particularly so if the stress and physical separation produced by having a hospitalized infant is complicated by illness of both mother and baby.

At the Hospital for Sick Children a multi-disciplinary research team conducted a two year project to evaluate self-help groups for parents of premature infants. The project team was made up of N. Shosenberg, RN, BScN; K. Minde, MD FRCP(C); P. Marton, PhD; B. Hines, B.Sc.; J. Shanoff, BA and D. Manning, B.Sc. Coordination of the parent groups was under the

direction of a nurse. Professionals were involved in both planning and functioning of the groups; this was considered necessary due to the nature of the crisis and to evaluate effectiveness of the project.

#### Project guidelines and objectives

Research criteria for inclusion of the infant and parents in the project were met if the infant weighed less than 1500 grams, was a singleton birth, had no congenital abnormalities, and at 72 hours of age had not suffered any major complications, e.g. intra-cranial hemorrhage, convulsions. Over the two

years of the project, 28 English-speaking families living within 15 miles of the hospital met this criteria and were willing to participate in the groups. In addition, 17 families who did not meet all the criteria were invited to attend the groups; this helped to fill out small groups when insufficient numbers of infants were born in close enough succession. The control group for the project consisted of 29 families who met the same criteria as the project group. Permission to include an infant in the project was given by the neonatologist and family pediatrician and the families were contacted by phone and invited to join the group when the infant was three days old.

Before determining research results the families in the two groups were matched for marital status, parity, previous abortions and socio-economic class. The majority of mothers were married (75 per cent approx.) and obstetrical histories showed a high incidence of previous obstetrical problems in both groups. The infants had mean birth weights of 1142 grams (S.D. = 215) and 1144 grams (S.D. = 249) in the experimental and control families respectively. There was an approximately equal distribution of male and female babies in the two groups.

The objectives for the project were the following:

- that parents have an opportunity to share and to learn to cope with the stress of having a premature infant
- that parents become acquainted with their baby in hospital, share in



Photos courtesy of E. Struthers

# Self-help groups for parents of premature infants

*Nancy Shosenberg*



meeting his present needs, and prepare to meet his future needs

- that parents be provided with general information about the characteristics and growth and development of premature infants
- that parents become familiar with the resources in the hospital and the community.

#### **Preparation phase**

The major initial task of the coordinator was to plan for the groups; this took approximately six weeks and included a variety of tasks:

**Resources:** A search for audiovisual and written resources was fruitless; as a result the following aids were developed:

- a slide presentation describing the neonatal intensive care unit at Sick Childrens
- a videotape entitled "Good things come in small packages" describing the characteristics of premature infants, the equipment used in N.I.C.U., and methods of feeding
- a kit containing the small equipment used in N.I.C.U. so that parents could handle these items that are sometimes frightening to the uninitiated
- a second videotape on prematurity entitled "A crisis for families". This video previously filmed by the research team and originally intended for professionals, was edited and adapted for parents.

Other films for new parents on general subjects such as bathing, breastfeeding, etc. were available for use if this type of specific information was requested.

**A special note:** discovering the lack of appropriate literature on prematurity, at the end of the project, the nurse coordinator produced a 60-page booklet with photographs entitled, "The premature infant: a handbook for parents" (see insert).

**Information gathering:** To become more familiar with the functioning and styles of other community self-help groups the coordinator met with some of these; this also prepared us for some of the problems that could arise within the groups.

**Consult with veteran parents:** A number of parents met with the research team to offer suggestions and to pilot evaluation tools. (A pilot group session had been held the year before and so we did not repeat this important preparatory measure.)

#### **Choosing veteran mothers for groups:**

This was a most important task; all veteran mothers were chosen for their role because of their interest in the project, their expressed desire to help other parents and their ability to

discuss their feelings openly and objectively. Some veteran fathers were also willing to participate and so some groups had this additional benefit.

**Staff preparation:** The staff nurses in N.I.C.U. met with the coordinator on a number of occasions to discuss the purpose and method of the project. The principal investigator interpreted the program to the medical community. All staff had an opportunity to preview any material that might be used in the group sessions.

**Arranging a meeting place:** It is difficult for parents to relax and discuss their concerns when they are in or near the busy I.C.U., so an office in the research department one floor away was chosen. With the addition of plants, brightly colored furniture, pictures and equipment for serving refreshments, it was transformed into a suitable meeting room.

#### **Project phase**

Once preparation for the project was complete, we were ready to start the group sessions. At this point the nurse-coordinator took on the duties of main organizer and facilitator of the groups. She was responsible for screening admissions, inviting parents to take part, arranging meeting times, providing A-V aids and scheduling participation of resource professionals in the groups.

The nurse-coordinator was also responsible for an initial individual

meeting with parents to orient them to the program. This was usually arranged to coincide with their first visit to the N.I.C.U. At this time they were introduced to their baby and the nurse caring for him, given a brief tour of the unit, and also introduced to members of the research team. At the conclusion of this visit the coordinator provided time for them to discuss their concerns about the baby.

Throughout the entire project the coordinator and the principal investigator attended rounds in the N.I.C.U. and the post N.I.C.U. This allowed them to act as a liaison between the ward staff and the research team members; it also provided a time to share the problems and progress of families with staff as necessary.

The whole research team met weekly throughout the project. These meetings were a time of evaluating the progress of the groups and a means of support for the coordinator. Between groups time was allowed for follow-up of the past group and preparation for the next one.

#### **The group setting**

Each group consisted of three to seven families and met weekly for approximately 10 weeks (range 6-14); each session was 1 1/2 to 2 hours long. The coordinator attended all sessions and veteran mothers were present for about half of the sessions; five of the eight groups had veteran fathers also attending. During the sessions the coordinator and veteran parents acted in team fashion; the coordinator took responsibility whenever special information or clarification was required.

Every group was different and therefore required a different approach; nevertheless, there were topics common to all of the groups. The initial three or four meetings focused mainly on the emotions of the parents, and coming to terms with the reality of having a premature baby. The next meetings were centered around parents' concern with their role of caretaking in the hospital and their infants' progress. Final meetings were oriented to the many aspects of care at home.

Conversations recorded during the meetings are included here to help give the flavor of the group sessions and to indicate how objectives were met in the self-help setting.

Most parents were trying to understand why their baby had been born early. Mothers had tremendous feelings of guilt that they had caused the prematurity; often they blamed the early birth on a drive over a bumpy road, a fall on the ice, or having intercourse. Despite good medical and self care during pregnancy, they still felt this way. Some parents knew the





medical reason for their early labor and this inevitably sparked a conversation of the causes of prematurity and recognition of high risk pregnancies.

The group setting usually provided the first opportunity to share delivery experiences with others without "feeling like a failure". Obstetrical complications are common to this group and so they readily understand each others' difficulties and frustrations.

Mrs. B: *They found out that my placenta was in the way when they did the ultrasound.*

Mr. M: *My wife had one of those ultrasounds done too. I'd never heard of them before.*

Mrs. B: *I'm glad they have them because from that I knew that bleeding was an emergency and we didn't waste any time getting to the hospital when it happened.*

Mr. B: *Eight minutes from our place to the hospital.*

Mrs. B: *They did a caesarean right away because the bleeding kept on.*

Mrs. M: *Oh, I had a caesarean too, but it wasn't for bleeding. I was in bed in the hospital four weeks before Anna was born. They were worried that I was getting toxemia because my blood pressure kept going up.*

Women normally feel vulnerable to danger in their third trimester; they are protective of their unborn child and are unwilling to give him up yet. When premature labor occurs and interventions from medical and nursing staff are necessary, women feel even more vulnerable, less able to protect their child and unable to control events. Mothers talked at length about these feelings of vulnerability and failure.

*"I knew something was wrong but I couldn't get anyone to believe me. It was the most terrible feeling — I knew the baby was coming but no one else seemed to. The nurse gave me some pills but I felt the same and rang for her again. I knew that I must seem unreasonable but I knew something was wrong and had to tell someone. She said I was too impatient. I phoned my husband and he believed me and told me to call the nurse again and ask her to stay with me. I was sure that both the baby and I would die. It was a real surprise when the baby was born and I heard him cry."*

Mothers who deliver early miss many, if not most, of the traditional social customs that accompany childbearing. This adds to their

unfamiliarity with their role and their alienation from friends and family who are also acutely aware of what makes up a normal childbearing experience. Mothers in the group shared a feeling of being cheated of one of the most dramatic events of a woman's life.

*"I couldn't believe I was in labor. I spotted all day before I realized what it might be. I hadn't even been to prenatal classes yet! My sister was having a shower for me in a month. It would have been next Monday. It's cancelled now. Everyone's too jumpy. When the baby was born they put me out. I missed the whole thing. Me! The girl who was going to have a natural childbirth. The whole thing's a flop. I didn't even get flowers in the hospital. Our family says to wait with the birth announcements — just in case."*

Mothers of premature infants go through a grieving process for the fantasy baby of their pregnancy as well as anticipatory grieving for the baby who may die. They perceive their symptoms of grief (inability to think about or concentrate on anything but the baby, crying, feelings of guilt, upset sleeping and eating patterns, irritability with others as depression, or inability to cope, as "going crazy", or as "serious postpartum blues").

Veteran mother: *The depression was the worst part of the experience for me. I can't say how long it lasted — it seemed like forever then. I got better gradually and then much faster when Andrew came home.*

Mrs. A: *At first I was okay and didn't see why anyone would want to come to a group. I understood everything about the baby and felt okay myself. But my next visit, I really collapsed and cried and cried when I saw the baby. It just*

*hit me suddenly and hasn't left since. Now I can hardly wait until our next talk. When I'm home I'm sure I must be going crazy.*

The reaction of relatives and friends to the baby's birth and to the parents' feelings were often an additional stress. Although one story of "I know a 170 lb man who was only 2 lb when he was born" may be reassuring, most parents find these anecdotes inappropriate because they bear little resemblance to the complex life of their tiny infant. Friends and family in their search to find some comforting aspect to the situation often receive a sharp rebuttal from parents.

Mrs. S: *My best girl friend came to the hospital to see me. I was glad to see her and told her about the delivery. She started to kid around and said I'd cheated because I didn't have to push the way she did to deliver her 8 lb baby. Imagine! My best friend said that!*

Veteran mother: *Most people don't know that it's usually harder work to have a premature baby than a full-term one because of the complications, never mind how you feel about it. If they only knew you'd push anything anywhere if it would help.*

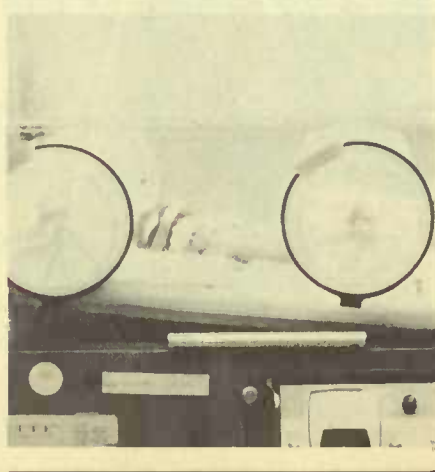
Mrs. S: *My best friend though! Well she sure isn't my best friend anymore.*

Parents shared many other concerns which professionals are often unaware of. These included the special role of fathers in this situation, the difficulties in providing a premie with breast milk, the stress associated with the transfer of baby back to the community hospital with a change in rules and staff, the economic strain of having a child in hospital despite medical insurance, the inflexibility of regulations for maternity leave and unemployment insurance benefits when a baby is born early, and the worry of finding a suitable babysitter for this special baby.

Parents took advantage then of the meetings to share with each other their reactions to having a baby prematurely. Being with others in a similar stressful crisis helped them to find a normal range of coping behaviors to events that are not part of the everyday world.

#### Problem sharing

The group sessions usually began with parents giving an update of their





infant's condition. Parents learned about prematurity, the equipment, and the complications of prematurity in these first weeks. This sharing, the slides, videotapes and veterans' experiences prompted a realization from the group that preemies have common characteristics and problems. Parents came to the group with questions to clarify their understanding of new terms. For example, a father had observed a notation on the Kardex which read "observe for bradycardia". The doctors hadn't mentioned this problem yet and he hoped that it wasn't a serious one. A mother had known about her baby's R.D.S. but when a new doctor referred to the baby's "lung disease" she was shattered. "Another problem with his lungs?" This mother stopped her daily visiting for one week. When she found that the two terms meant the same thing her fear lessened and visiting the baby resumed.

Parents shared both progress and problems. A decrease in the baby's oxygen requirements or an increase in the number of cc's of milk being consumed brought cheers from the group. Apnea, patent ductus arteriosus or a return to ventilation brought sympathy. When a baby became ill the parents regressed in their hope and re-experienced grief symptoms.

Mrs. R: *Apnea! That's been the most terrible experience yet.*

Mr. L: *What did you do when it happened?*

Mrs. R: *I went to pieces. I ran from the room and yelled for a doctor to help me. I was crying and saying "Please help me - my baby's not breathing". The nurse said it was okay and that he was going to be all right. I went back in and he was okay. I was so embarrassed and apologized to the nurse for acting like that. I was so scared it would be a bad one like before. I'm afraid to leave the hospital in case he has another one.*

Veteran mother: *I was always afraid to be there when Sarah had one. I just wanted to leave and have nothing to do with it. It was the same when they took blood. I just couldn't stay there. I'd go home and cry. Then I'd feel so bad because I'd left her. What kind of a mother was I anyway - I couldn't even stay there when she had her worst times. It was a big day for both of us when I could stay and hold*

*her hand while they took the blood from her heel.*

### Professional input

As parents became more involved in the daily care of their baby, they asked for information on parenting in the hospital setting and at home.

The veteran parents were helpful in putting relationships with staff into perspective.

Mrs. D: *These nurses think he's their baby and he's not!*

Veteran mother: *I used to think that too.*

Mrs. D: *When I was here yesterday the nurse kept doing things to Sacha when I could hardly wait to get in there and hold him. I was so mad - it was like she was doing it on purpose.*

Veteran mother: *Probably she was doing it on purpose so you could have Sacha to yourself after everything was finished - with no interruptions.*

Mrs. D: *Do you think so? That's what she said too, but I didn't believe her. I guess you're right. I'm so upset - I react to everything.*

Three professionals had regular input with each group. A neonatologist from the N.I.C.U. came midway in group meetings to answer medically-oriented questions and to discuss taking the premature baby home. He also told the group about current trends in perinatal care; many parents had not heard such terms as "high-risk pregnancy" and were unaware of new facilities and philosophies in care.

The occupational therapist from the N.I.C.U. came to a session to discuss the abilities of infants (many

parents are surprised that preemies can hear and see) and the developmental tasks to be achieved in hospital and at home. She also stressed the valuable input parents can have during their baby's hospitalization.

The nurse from the follow-up clinic attended to familiarize parents with the function of this clinic and to discuss common concerns parents have when taking their baby home. In addition she reviewed the important concept of age correction used to assess premature babies in the first few years.

Sometimes discussions that developed showed a need for further interpretation of professional roles; for example, the parents in one group interpreted the "public health nurse" visit as a sign that the hospital knew the mother wasn't coping well and was sending someone to check up on her. A P.H.N. was invited to the group to clarify.

A nutritionist was also available to the group whenever her expertise was required.

### Research results

Each family was interviewed by the team psychologist at the time of the infant's discharge from N.I.C.U. This interview was designed to determine the parents' feelings on seven separate issues:

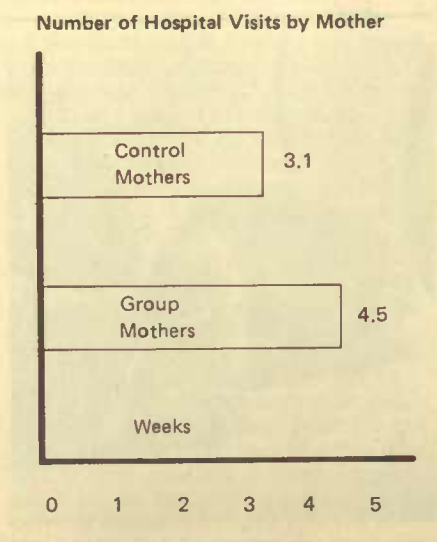
- satisfaction with medical care
- satisfaction with nursing care
- satisfaction with information
- understanding of the infant's condition
- interaction with other parents
- comfort with ability to care for baby at home
- knowledge of community resources.

Each of these was scored from 1 to 5, most unsatisfactory to most satisfactory, so that a total score could range from 7 to 35. Each category had a clear definition that allowed for objective scoring. Scoring on all seven issues was significantly different when the groups were compared; the project group demonstrated higher scores in every case (total mean scores: project: 28.7, control 22.1).

Attendance rates for the group sessions were also studied; the mean attendance was 65 per cent. The mothers whose attendance was below 50 per cent were all from families with special individual problems; this group, experiencing multiple crises, seemed unable to focus consistently on the infant.

The mothers in the project group visited their infants in N.I.C.U. significantly more often than mothers in the control group (See figure one). This outcome strongly suggests that participation in the self-help groups encouraged mothers to visit more often.

Figure one





When parents visit frequently staff have a better opportunity to promote solid parent-infant relationships. The mean stay for all 57 infants in N.I.C.U. was 55 days; they returned to their community hospital when their weight was approximately 1800 grams and their medical status was stable.

In the comparison of statistics on length of separation for mother and infant (birth to first visit) a difference was noted again between the two groups: project mothers had a shorter separation time. This could have resulted from the early call to the mother inviting her to join the group, however, as illness of the mother after birth would also increase separation time, this cannot be accepted as the only interpretation.

### Conclusions

The entire course of pregnancy and childbirth is often very different for these parents: they have probably missed prenatal classes, been separated by hospitalization before birth, estranged from the baby soon after delivery, and required to adjust their version of a "normal" newborn. They are also subjected to a greater diversity of professionals and technology. By setting up these group sessions the research team hoped to offset the negative effects of all these differences, and capitalize on the strength of other parents with similar past experiences. Also this was a way for professionals to fulfill their responsibility to give information and support to these parents, and to do this in an innovative manner.

Group support is beneficial to many but it may not be appropriate for everyone. One of the project's problem areas was encountered when attempting to meet the needs of families with special problems, e.g. no housing, marital problems, psychiatric illness, unemployment, etc. Recognition of and provision for these families became a responsibility of the coordinator; support from other professionals was essential for helping these families cope.

The results of this study strongly suggest that the objectives of the self-help program were attained. Sharing common problems helped parents recognize and accept their crisis reaction as normal. It showed also that parents can care for their infant in hospital when they are ready and accepted; it demonstrated that they are eager to learn about prematurity and the special needs of their baby.

### The Premature Infant

by Nancy Shosenberg, RN, BScN

This 60-page booklet on prematurity, subtitled "A handbook for parents", has been prepared as a self-help aid. It covers all aspects of infant care in excellent detail using language appropriate for parents unfamiliar with the characteristics of a premature baby and the technology of care. Numerous photographs add visual reality to the text and convey a sense of warmth and support. This booklet is a bonus for worried parents needing information and an A-1 aid for staff to use in their "patient educator" role.

The booklet is available from the following addresses:

In Ontario order from:  
Health Resources Centre  
Communications Branch  
Ministry of Health  
Hepburn Block, 9th Floor  
Queen's Park, Toronto M7A 1S2

Other provinces:

The Hospital for Sick Children  
Room 1218  
555 University Avenue  
Toronto, Ont. M5G 1X8

Cost: In Ontario the booklet is available free to families with a premature infant.

Other provinces: single copies—\$3.00 each  
50-99 copies—\$2.50 each  
100 or more—\$2.00 each

Difficulties for the coordinator included meeting the wide range of needs in the different groups, and the flexibility required to handle each group in an individual way. A positive outcome was the development of an educational role for the nurse coordinator. Staff in N.I.C.U. and parent-oriented groups asked for



dialogue, inservice sessions, workshops and conferences. These groups wanted to learn about the role of the caregivers and the experiences and needs of the family with a premature infant.

Undoubtedly the single most obvious indication of the program's success has been the subsequent formation of the Toronto Perinatal Association; this organization of parents continues to make self-help groups available for families coping with prematurity at the Hospital for Sick Children. ☺

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Nancy Shosenberg was nurse coordinator for the project described in this article. She is a graduate of the Nightingale School of Nursing, Toronto, has a diploma in neonatal nursing from The Hospital for Sick Children and a BScN from Queens University, Kingston, Ontario. She is employed by the Department of Psychiatric Research at The Hospital for Sick Children, Toronto.



# Income Tax and the Self-Employed Nurse



Tax is due on income as it's earned. You're required to pay the tax on your self-employed income in four equal instalments — March 31, June 30, September 30 and December 31. It's to your benefit to make your payments regularly to avoid being faced with an unmanageable tax bill and penalties at the end of the year. When you file your annual tax return, on or before April 30, you pay the difference between the amount you've already paid by instalment and the amount of tax due. If you have overpaid, you will receive a refund of the overpayment. Interest is charged on late or insufficient payments.

Instalment payments may be made where you usually bank or you can send them to the Taxation Centre serving your region. When making your first instalment payment, however, mail it to the Ottawa Taxation Centre, Ottawa, Ontario, K1A 1B1. Identify the payment as a quarterly instalment. Include your name, address, date of birth and social insurance number on the face of your cheque or money order, which should be made payable to the Receiver General for Canada. Do not send cash through the mail. Revenue Canada, Taxation will send you a combination receipt (for your records) and remittance form (for making your next payment).

**Canada Pension Plan and UIC**  
Like most working Canadians between 18 and 70, you are required to contribute to the Canada Pension Plan unless you live in Québec where the Québec Pension Plan is in effect. Your CPP contribution is paid by instalment at the same time as your income tax. Your contribution is based on maximum earnings of \$13,100. You would not contribute any amount for earnings above that level. In doing the actual calculation, however, there is a basic exemption of \$1,300 which you subtract from your income.

If your income happened to be \$13,100, you would subtract the basic exemption of \$1,300 and calculate your CPP contribution as 3.6 per cent of \$11,800.

## Employee or self employed?

How is your employment status determined? Basically by the amount of control the contracting client or company has over your work. This is usually made clear at the onset by the terms and conditions under which your nursing services are to be performed. *If you exercise control over the hours of work, the premises and equipment used and the manner in which you perform your nursing duties, you will probably be considered self-employed.*

If, on the other hand, the hospital, clinic, nursing home or doctor's office pays you a salary, has the right to discharge you, and has established definite working hours, you will be considered an employee. If you have any doubts, you can obtain a specific ruling from your District Taxation Office.

Once you've determined your employment status, how do you report your earnings? Remember that as a self-employed nurse in Canada you won't have the help of that handy T4 Supplementary that employers send to their employees each year to provide a record of their annual earnings and deductions. You'll have to keep track of these yourself. In addition, tax won't be deducted at source on your self-employed income. It will be up to you to calculate the amount you owe and send it to Revenue Canada, Taxation.

You are required to pay tax by instalment if the tax on your earnings will amount to more than \$400 for the year or the immediately preceding year. Unless three-quarters of your income (both self-employed or other income) is taxed at source, you are expected to pay tax by instalment.

*In Ontario alone, at least one nurse in 60 is in private practice. That province's licencing body, The College of Nurses, estimates that last year close to 1000 nurses out of a total of 59,875 employed RN's were self-employed.*

Maureen Garbutt

Do you dream of becoming your own boss? Or maybe you already enjoy the freedom of choosing your own hours and working conditions? Being self-employed can be very satisfying but it requires a business-like attitude to some things you once took for granted: it's important, for example, that you fully understand the tax implications of your decision. One of the first things to consider is whether or not you really are self-employed for tax purposes. This is important because it determines the deductions you may claim.



If you earned more than \$13,100 (for example \$16,000) you would subtract the \$1,300 basic exemption, which leaves \$14,700, an amount greater than the \$11,800 maximum contribution. In that case you would pay 3.6 per cent of \$11,800 which is \$424.80 (or \$106.20 each instalment).

If you earned less than \$13,100, for example \$5,000, and as this amount is less than the \$11,800 maximum contribution, you would pay 3.6 per cent of \$3,700 (\$5,000 minus the \$1,300 basic exemption) or \$133.20 (\$33.30 per instalment).

If you've already contributed to the Canada Pension Plan as an employee, then the salary or wages on which you made a contribution are taken into account. For instance, if you've made the maximum contribution for a year as an employee, no contribution is required on your self-employed earnings for that year.

As a self-employed nurse, you are not required to pay Unemployment Insurance premiums.

#### It's wise to keep records

It's not hard to see that good records can work to your advantage. Remember, you'll need detailed information on your self-employed earnings and related expenses in order to estimate your tax due and calculate your Canada or Québec Pension Plan contributions. At the end of the year you'll need all these details to complete your tax return accurately. Well-kept records can save you tax, as they can remind you of the deductible expenses available to you.

One method of maintaining records is a two-file system — an active file and a dead storage file. Your active file should hold unpaid bills, paid bill receipts, current bank statements, cancelled cheques and income tax working papers. These should be arranged in envelopes which have been clearly labelled as to contents and filed by year. Keep records up-to-date by cleaning your active file annually and moving older records to the dead storage file. You can use anything from a metal filing cabinet to manila folder. The essential thing is to know where everything is.

One handy record is a diary of your expenses. At the end of each day, simply write down all of the amounts you have spent in order to earn income, pay telephones, parking fees, gas and oil purchases, etc. Where possible, ask for receipts which you can keep on file to substantiate your expenses. You'll probably be surprised at the amounts you spend that are deductible for tax purposes. Maintain a written record of those expenses for which you have no receipt, noting names, amounts, dates and places. This information will help justify your claim for expenses.

You are required by law to keep your records and supporting documents from year to year until you request and obtain written permission from the District Taxation Office for their disposal.

#### Your fiscal year

Except for farmers and fishermen, virtually all self-employed taxpayers must follow the accrual approach to accounting. This means that income is reported in the year in which it is earned, regardless of when payment is received. Allowable expenses are deductible in the year they are incurred whether paid or not.

As a professional nurse, you are allowed to use a modified accrual method. Income is treated as being earned when accounts are sent, providing there is no undue delay in delivering them.

For example, suppose you had billed a client for nursing services but had not been paid when it came time to determine your income for the year. That unpaid amount would still have to be included in your income but you would not have to report it for that year if you had not yet billed your client.

Individuals are taxed on a calendar year basis. However, as a self-employed nurse, you can determine the dates of your own tax year. This fiscal period may coincide with the calendar year but must not be longer than 12 months. If you don't pick a year-end to report your self-employed income, you'll automatically be given the normal calendar year-end. By choosing a year-end other than December 31, you might be able to maximize certain allowances.

Your fiscal period is established when you file your first income tax return. Once you have selected a business year, though, you are not allowed to change it without first obtaining permission from your District Taxation Office. A change will not be permitted if your main reason is to minimize taxes.

Suppose you choose January 31 as your year-end. What you earned as a self-employed duty nurse between February 1, 1979 and January 31, 1980 would not have to be reported until you filled out your 1980 tax return — and you don't do that until early 1981. So although you earned your self-employed income during 11 months of 1979, because your year ends in 1980, you don't have to report any of that income until 1981.

If you had other income as well, for instance employment or investment income, you would report it on the same tax return but it must cover the taxation year running from January 1 to December 31, 1979. That's why it's usually easier for taxpayers with both kinds of income to use the regular taxation year as their business year as well.

**Reporting your self-employed earnings**  
You will be reporting your self-employed income on the line for "Business income" on the first page of your tax return. You are required to report both gross and net income.

Gross income is your total earnings as a self-employed nurse. Net income is what you end up with when you subtract the allowable expenses you incurred to make those earnings.

To support the net income figure you arrive at, you are required to file a statement of income and expenses and a balance sheet with your tax return. Form T2032 (available from your District Taxation Office) is a useful checklist for expenses you may have forgotten to claim.

Generally if you incur an expense to earn income, the expense is deductible for tax purposes. These expenses must be reasonable and must relate to the year in which you are deducting them. You should keep all the receipts, cancelled cheques, etc. necessary to support your claim for expenses in case Revenue Canada should question them. If you're asked to prove you made an expenditure and you do not have supporting evidence, your claim could be disallowed. Complete documentation also enables you to prepare your tax return more quickly and accurately and can remind you of deductible expenses which you might otherwise overlook.

These individual expenses may not seem like much, but over a year they add up. Items most commonly claimed by self-employed nurses relate to automobile and transportation expenses, office upkeep including telephone costs, nurses' uniforms and shoes, and professional conventions and courses. Here's an alphabetical list of the expenses you should be aware of. *Remember though, that these deductible expenses apply only to income earned from self-employment:*

#### Accounting and legal expenses:

Accounting fees for the preparation of your income tax return are deductible. Any legal expenses incurred to collect unpaid earnings owing to you can also be claimed.

**Advertising expenses:** You may deduct the cost of running an advertisement in a Canadian publication to tell of your availability to perform nursing services. Business cards may also be claimed as an expense.

**Automobile expenses:** If you own an automobile that you use in the course of your work, you may claim automobile expenses. If you use your automobile partly for business and partly for personal use, you claim only that portion of the total operating expenses that relate to your working use. Thus, if your business mileage is 12,000, your total mileage 20,000, and the operating expenses for the year amount to \$1,500, your deduction would be  $\frac{12,000}{20,000} \times \$1,500$ , or \$900.

20,000



Driving back and forth between your home and the place where you work is *not* considered business use and cannot be included in your business mileage.

If you own and use two automobiles, you are not allowed to claim total expenses for both; you must allocate expenses for each.

Operating expenses include automobile licence and insurance fees as well as washing, gas, oil and routine maintenance and repairs. You can also claim capital cost allowance on your automobile, interest on a loan made to buy it, or rental costs if you are using a leased automobile. Remember that you claim only the amount related to your business use of the car.

To claim these expenses, you will need to keep receipts for all operating costs. You will also need a record of your total mileage and business mileage. If you change automobiles during the year, record the mileage for each one when you start or stop using it. To claim capital cost allowance, you must have the original bill of sale for your car, or if you have an older car, record its value when you first begin to use it for business purposes.

**Bank charges:** If you have a special chequing account for your self-employed earnings, you can claim cheque, money order and similar charges.

**Books and magazines:** You may deduct the cost of single issues of magazines and library fees for books necessary to keep your nursing skills up-to-date. You can also deduct fees paid for nursing library privileges.

**Canada and Québec Pension Plan contributions:** Contributions you make to either plan are deductible.

**Capital cost allowance:** The cost of acquiring a capital asset (an automobile, typewriter, etc.) is one outlay not deductible in full for the year it's incurred. As this kind of asset is expected to have a useful life of more than one year and to be of long-term benefit, it is deductible over a period of years rather than the year of purchase. This is called "capital cost allowance" or depreciation.

This deduction is available to all self-employed taxpayers and covers many types of assets, such as vans, office furniture and equipment. Not all capital assets qualify for capital cost allowance, however. To qualify, a capital asset must be included in a class specified by law. Rates for these classes may be obtained from your District Taxation Office.

Automobiles are in Class 10, where the rate is 30 per cent. Thus, if the undepreciated capital cost of your automobile was \$8,000 at the end of last year, your capital cost allowance rate is 30 per cent of that, or \$2,400. This amount is subtracted from the undepreciated capital cost of your automobile, and next year's claim would be based on \$5,600 (\$8,000 minus \$2,400).

If you use your automobile for both business and personal use, you may claim only that portion of the depreciation that relates to your business use. Thus, if your business use is 35 per cent of your total use, you can claim only 35 per cent of \$2,400 or \$840. If your business use was 50 per cent, you could claim \$1,200, and so on. Note, however, that your capital cost for the following year would still be \$5,600, no matter what the ratio of your business use.

If you sell your automobile for more than the undepreciated capital cost, you must include in your income the difference as a "recapture" of the capital cost allowance you have claimed in previous years. "Recapture" applies only to capital cost allowance you have previously claimed, not to any profit you might have made when you sold the car. If you sell your car for less than the undepreciated cost, you may also be entitled to claim a terminal loss on the difference.

**Convention expenses:** You may claim only two conventions a year and they must relate to earning your income. In addition, they must take place within the territorial scope of your business. You don't need to be a member of the association holding the convention but your attendance must have a direct bearing on your way of earning income.

**Entertainment:** Expenses you incur to entertain clients are deductible provided they are for business purposes. Expenses must be reasonable under the circumstances and supported by appropriate receipts and records. Undated restaurant stubs are not acceptable as receipts.

**Losses:** Business losses are generally deductible. For example, if your expenses for a year should exceed your earnings, then you may claim a business loss.

**Memberships:** Annual dues to maintain memberships in trade, professional or commercial associations are deductible only if they are necessary to earn income. Lump sum life memberships are deductible if they substitute for annual membership fees. These may be deducted for the year in which they are paid. Admission or initiation fees are not deductible.

**Office expenses:** To claim a deduction for an office in your home, you must have a room set aside for the sole purpose of earning income. It cannot also serve another purpose, for example, a sewing room or workshop. You must establish clearly that your office is separate from your living quarters and that a substantial amount of your business is conducted there.

If that is the case, you may deduct a reasonable portion of your home expenses. These include such items as electricity, heating, taxes, home insurance, general maintenance and repairs, etc. The expenses must be apportioned between the business and non-business use of your home. This is done by dividing the square feet or number of rooms for your business by the total square feet or number of rooms of the entire house. You may also claim a deduction for capital cost allowance or mortgage interest provided you own the home. Remember, however, that if you claim these deductions you might affect the "principal residence" status of your home. If your office is in a rented house or an apartment in which you live, you may deduct the portion of your rent that can be attributed to your business use.

**Supplies:** Any supplies that you use in the ongoing performance of your work are deductible. This might include street maps, stationery, stamps, medical equipment, etc.

**Telephone bills:** You may not deduct telephone charges unless the telephone was installed specifically for business use. The cost of long distance calls are deductible if you can show they were incurred for earning your self-employed income.

**Travel expenses:** Travel expenses are generally considered personal living expenses and are not deductible (except for attending conventions as discussed earlier). However, taxi charges, bus fares and parking fees incurred in carrying out your nursing duties are deductible if you have to travel away from your normal place of business.

**Tuition fees:** Tuition fees for taking a course or seminar related to nursing are deductible. However, you cannot deduct travel expenses if the course or seminar is out of town. ♣

## Resources

For more information on specific topics ask your District Taxation Office for:

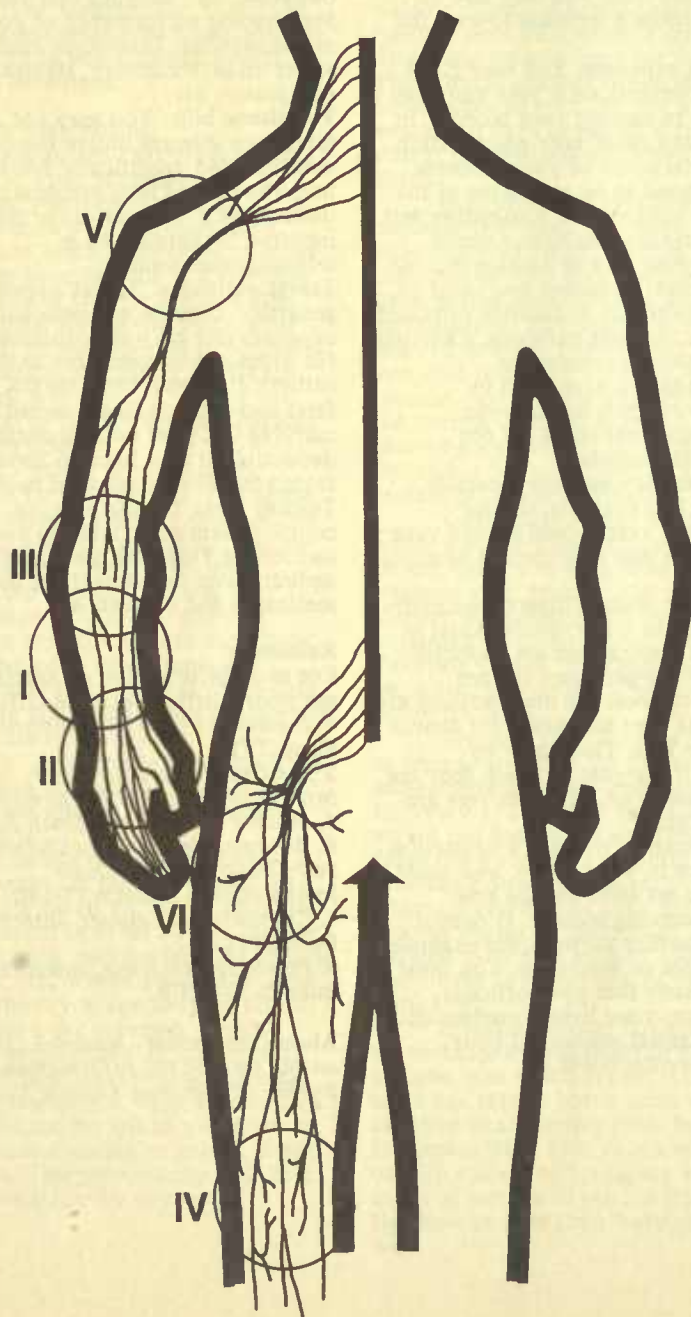
1. *Instalment Guide for Individuals*, Form T7B.
2. *The Canada Pension Plan — Information for the Self-Employed*.
3. *Income Tax and the Small Business*.
4. *Automobile Expenses Claimed by Self-Employed Individuals*, Interpretation Bulletin IT-180.
5. *Convention Expenses*, Interpretation Bulletin IT-131.
6. *Principal Residence*, Interpretation Bulletin IT-120R.

**About the author:** Maureen Garbutt is on the staff of the Information Services Branch of Revenue Canada Taxation.



# Nerve Palsies: the preventable sort

Christine McNamee Bruce Maclean



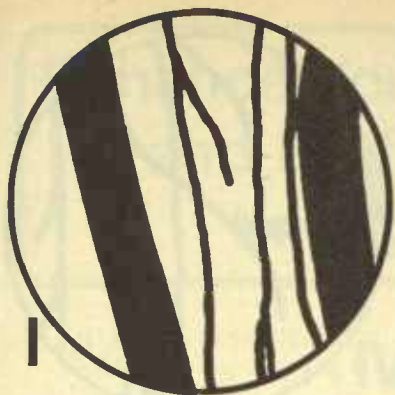
Larry, a twelve-year-old boy, has undergone elective surgery for repair of a nasal septal defect. Shortly after his return to the ward from the post-anesthetic recovery room, he complains of numbness and tingling in his left hand. Upon investigation you find that Larry has a markedly weakened grip. Larry is a victim of ulnar nerve palsy, a complication which can occur during the operative or post-operative period, due to lack of knowledge or vigilance on the part of nursing staff.

Mrs. S., a 78-year-old woman with diabetes, has her right foot amputated for gangrene. During her recovery from surgery she has a metal cradle on her bed to relieve the pressure of bed clothes. Her left leg has diminished sensation: she does not feel it pressing on the edge of the metal cradle. When you help her up for the first time you notice that she has foot drop. She too is a victim of a preventable nerve palsy.

Peripheral nerves are readily damaged, particularly at certain sites along their course where they are relatively superficial and unprotected. The damaging assault to these nerves is usually excessive pressure or stretching, or a combination of both these forces. Less often, nerves are directly damaged by injections; either the needle itself or an irritating substance injected into or surrounding the nerve being the cause of injury. The risk of injury to peripheral nerves is greatly increased in patients with conditions making them susceptible to neuritis, e.g. diabetes, alcoholism. Hypothermia is also another predisposing factor, whether due to exposure or induced as an operative adjunct.

What nerves are prone to injury? Where are the vulnerable sites? What are the sources of this pressure and stretch that could result in nerve damage? What signs and symptoms indicate a nerve palsy? The following discussion of six individual nerves and one plexus should help answer these important questions.





**I** The most vulnerable of the peripheral nerves is probably the **ULNAR NERVE** which surfaces directly behind the medial epicondyle of the humerus. The nerve lies beneath a sharp-edged aponeurosis, and is otherwise subcutaneous at this point. Thus pressure can be exerted on it in a number of ways. For instance, an arm, unattended during surgery, can drop over the side of the table and rest on the metal railing, or press on the hard table top if the mattress has shifted slightly. Similar hazards exist in a bed with side rails or on a stretcher with a hard rubber bumper. Hyperflexion of the arm pulls the nerve tightly across the condyle; prolonged stress of this sort can damage the nerve as well. Compression is more likely to occur if the arm is pronated than if supinated. Other sources of compression include blood pressure cuffs, pneumatic tourniquets and stethoscopes strapped to the arm for long periods.

The ulnar nerve controls the muscles of the flexor side of the forearm and the ulnar border of the hand, the small muscles of the hand and the flexor muscles of the fourth and fifth fingers. Similarly, the sensory distribution covers the ulnar border of the forearm, continuing along the fifth finger and the lateral half of the fourth finger. From this pattern of innervation it is easy to see that damage to the ulnar nerve is no small matter. If an injury has occurred the patient will usually complain of numbness and tingling along the ulnar border of the hand, especially in the fifth finger. In an advanced case, there will be some small muscle wasting and weakness in the ulnar half of the hand, with clawing of the fourth and fifth fingers.

Perioperative palsies have not been frequently reported upon, but the prognosis has usually been considered good. A more recent detailed study by Miller and Camp suggests otherwise.

Recovery may be slow, and permanent dysfunction has been reported. In the meantime it is essential that the nerve be protected from further insult, and that the fingers and affected hand be exercised regularly. If necessary, the fingers and hand should be splinted to maintain normal positioning.

**II** The **RADIAL NERVE**, is not as commonly involved as the ulnar, but it must also be considered at risk. Leaving the brachial plexus, it winds around the back of the humerus and becomes vulnerable at the mid-point of the humerus. It is particularly susceptible to pressure, especially when the patient is in the lateral position with additional weight of the head resting on the arm. A call bell or bed rail left lying beneath the arm can create pressure points, thus increasing the possibility of nerve damage. An unconscious patient requires careful observation because he can easily fling an arm out over the side of a bed or a stretcher in such a way that pressure is exerted on the nerve by the bed's edge. Armboards carelessly applied can also serve as a source of damaging stress to this nerve.

The radial nerve serves the flexors and extensors along the radial border of the hand, and provides some sensory function to the back of the hand and the thumb. The results of radial nerve palsy are variable. Frequently the patient develops a wrist drop because of the loss of function of the extensor muscles; there may or may not be any significant sensory loss in the hand. The prognosis is good, but a wrist splint will be needed to maintain proper positioning, and regular physiotherapy will be required to regain function.

**III** The **MEDIAN NERVE** is at risk in the peri-operative period from injections. A needle placed in the ante-cubital vein or in the brachial artery may slip off to the side, or the injection may be aberrant; in either case, damage to the median nerve is

possible. The median nerve carries motor impulses to many of the small muscles of the hand, and sensory impulses from the central portion of the palm. Thus patients with median nerve damage will likely have muscle wasting and weakness of the hand, as well as sensory loss in the palm and fingers. Peri-operative damage of the median nerve is not frequently encountered; symptoms of this palsy are fairly often seen in people with Carpal Tunnel Syndrome.

**IV** The **LATERAL PERONEAL NERVE** is a superficial nerve which can be readily damaged. It winds around the head of the fibula on the outer aspect of the leg and serves the muscle groups on the frontal aspect of the tibia which are responsible for elevating the foot. This nerve also carries sensory impulses for the dorsum of the foot. It can be damaged when a patient is placed in unpadded stirrups, or when the legs are improperly positioned. There is also great risk of injury to this nerve when an unconscious patient is left in the lateral position with insufficient padding or excessive weight on the legs. Tensor bandages applied too tightly can also be responsible for this palsy; diabetics or older individuals with arteriosclerotic disease are the most likely candidates. Foot drop is the most dramatic symptom of lateral peroneal nerve damage. Splinting and regular physiotherapy will be essential to correct this serious problem. Recovery can be expected to take considerable time.

**V** The **BRACHIAL PLEXUS** is a complex of nerves arising from a band of spinal nerve roots from C4 or 5 down to T2 or 3. These combine, divide and recombine in intricate patterns along their course. The main pathway they follow travels over the first rib and below the clavicle. This point, called the thoracic outlet, is the vulnerable area.





The causes of stress can vary: some people have an additional cervical rib which adds extra stress; others have a tight scalene muscle, which tends to pull the first rib up closer to the clavicle, or there may be abnormal vessels or fibrous bands present in the area. All these conditions can keep the nerves of the brachial plexus in a continual state of stretch and any additional stretch or pressure will usually suffice to produce a palsy.

There are several surgical or physical stresses that can be exerted on the nerves arising from the brachial plexus. Placing a patient in steep Trendelenburg position, for example, requires the use of shoulder braces; if these are applied too far medially, the pressure between the clavicle and the first rib can be increased. Positioning the arm of an unconscious patient beyond a 90° angle from the body (which can occur accidentally if the arm falls backward without support), results in excessive stretching of these nerve fibres, particularly if the situation is aggravated by rotation of the arm. The rather marked relaxation techniques sometimes used in the process of surgery can produce such lack of resistance in the shoulder girdle, that any additional pressure is passed straight through to the small thoracic outlet. Since the nerve trunks arising from the brachial plexus continue on to become the ulnar, the radial and the median nerves, any of the symptoms previously mentioned can result from pressure on or stretching of these nerves. The most common would likely be ulnar discomfort, i.e. pain, numbness, tingling and eventual wasting of the small muscles in the hand in instances of prolonged insult.

**VI The SCIATIC NERVE** is not likely to be affected directly by positioning. It is primarily at risk from injections. This nerve is sufficiently superficial in some people that it can be directly damaged with a needle. Chronic back problems, with lumbar disc degeneration, old injuries and spondylolisthesis, however, cause a certain amount of continuous stretch of the nerve fibres. If the nurse can provide a degree of flexion either at the back or behind the knees, this stretching is relieved, and pre-existing sciatic pain or disease is less likely to be aggravated.

The prognosis with sciatic nerve palsy is good, although it may take from many months to more than a year for complete return of function. The treatment is usually supportive. Splinting is required when there is some loss of motor tone and abnormal positioning. Physiotherapy will maintain circulation and restore muscle strength. Analgesics should be given as necessary to relieve the accompanying discomfort.

**VII The FACIAL NERVE**, although rarely involved, is at risk in the peri-operative period as well. A branch of this nerve surfaces immediately anterior to the parotid gland. Undue pressure on the face, such as that produced by a tight head harness, can produce facial nerve palsy. Since this nerve serves the orbicularis muscle, the result could be weakening of the affected side of the face such as that seen in Bell's Palsy.

#### Nursing implications

Prevention of nerve palsies is simple and basic nursing care. To be competent in this area, the nurse requires fundamental knowledge of the following:

- vulnerable nerve sites
- a sound sense of proper positioning
- awareness of environmental hazards.

More specific suggestions for nursing care include:

- use of foam padding for elbows in the operating room
- avoidance of all inflexible surfaces
- constant alertness to positioning of the unconscious or unaware patient
- generally keeping limbs slightly flexed
- special precautions with armboards, stirrups, braces, harnesses, bandages, etc.
- correct and cautious injection technique
- extra vigilance with predisposed individuals, e.g. those with diabetes, alcoholism, or hypothermia.

Through quality nursing aimed at preventing palsies, nurses can protect their patients from needless suffering and the prolonged treatment necessary to regain healthy nerve tissue and functioning. ♡

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Christine McNamee, RN, BScN, is currently administrative supervisor, Inservice Education, at Nanaimo Regional General Hospital on Vancouver Island.

R. Bruce Maclean, MD, has been an anesthetist at this same hospital since 1962. The idea for this article came from a lecture on the subject that he gave recently to the hospital nursing staff.



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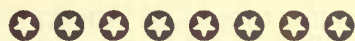


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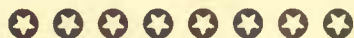


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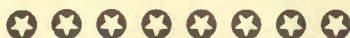
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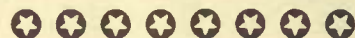
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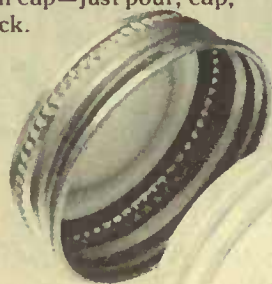
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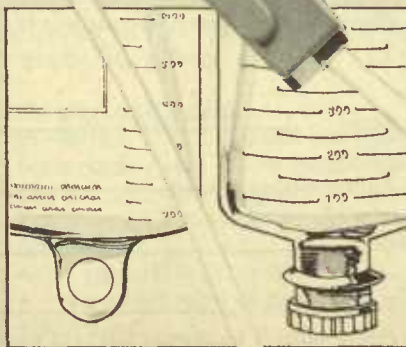
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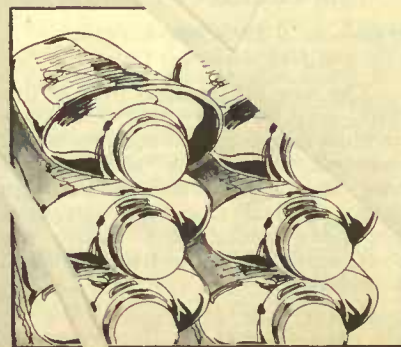
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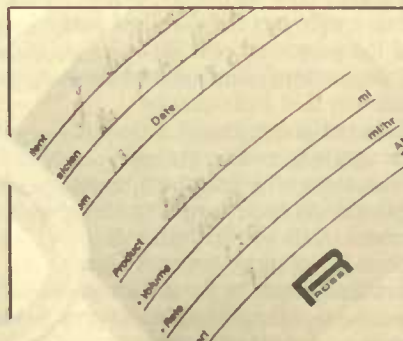
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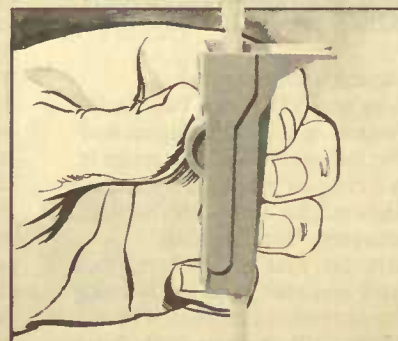
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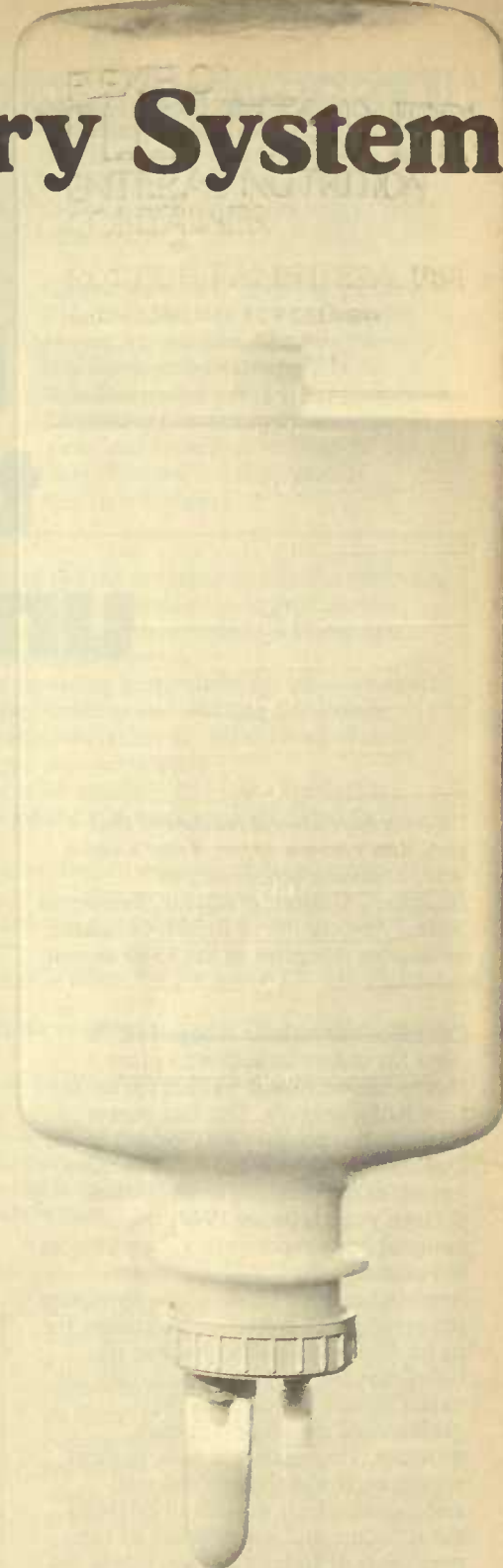
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## Part 1\*

# Nurses take the union route

Glenna Rowsell

*"Nurses have always fantasized that they don't have a union. I don't know why, because a union we got."*  
(Stephany Grasset, president, Registered Nurses Association of British Columbia, addressing delegates to the 1980 annual meeting.)

Canadian nurses have recognized the need for collective action to protect their socio-economic welfare for more than half a century. The first nurses' union in this country was formed in the Québec City area in 1928 and became known as the Catholic Nurse Union. Sixteen years later, in 1944, the national body representing nurses across the country, the Canadian Nurses Association went on record as approving the principle of collective bargaining for its members and publicly stated its belief that the bargaining authority for nurses should be vested in the professional association in each province. The result was that, in most provinces, it was the professional association which worked to establish the structure and constitution of the precursors of today's unions. It was the professional association, too, which in most instances pressed for changes in

the nurses acts and by-laws of each province that would permit these associations to bargain collectively and, it was hoped, to act as bargaining agents for their members.

In 1946, the Registered Nurses Association of British Columbia became the first provincial association in Canada to apply for certification for all registered nurses in that province under the Labor Relations Act of BC. Certification was granted and the RNABC thus became the first professional association to achieve the status of bargaining agent.

The remaining nine provincial associations continued to assume responsibility for the social and economic welfare of their members, including the publication annually of recommended personnel policies and distribution of these to both nurses and their employers. The main objective in doing this was to provide nurses with employment standards and recommended salaries that they could use to support negotiations for better working conditions and salaries.

Ultimately, however, both sides came to realize how ineffective this tactic was: employers for the most part regarded the personnel policies as merely "suggestions" and ignored them. The result was that little change occurred in the employment situation and nurses grew to realize that, if change was to be effected, there must be a revolution in their approach to employment relations. Professional associations, reacting to pressure from their members, began in the sixties to develop collective bargaining structures and to prepare for more formal negotiations with employers. The nurses

themselves began to organize local staff associations which closely resembled local union or bargaining units in industry.

In most cases, the professional association in each province could not achieve certification as the appropriate bargaining agent for its members because of conflict with existing labor legislation.\*\* In Canada, laws governing collective bargaining are under the jurisdiction of both the provincial/territorial and federal governments. These acts are administered by the Labor Relations Board in each province which also determines the level of employees eligible to become members of the bargaining unit. In determining the appropriate unit, each board must comply with the definition of "employee" described in its provincial act. Nursing classifications included in provincial bargaining units therefore differ from province to province. The fact that some of their members were classified as "management", meant that professional associations, for the most part, could not qualify under the Labor Act to serve as bargaining agents. To bargain without the protection of the Labor Act was unthinkable since employers, faced with such a situation, could simply refuse to negotiate. Thus, nurses found themselves coming under the definition of a trade union as determined by existing labor legislation.

\*\*The exception was Prince Edward Island which *does* have collective bargaining rights under the Nurses Act of PEI.

\*Nurses unions, professional associations and YOU" is a two-part special feature in the July/August and September issues of CNJ. The series is based on a chapter prepared by author Glenna Rowsell for a new textbook for nurse managers, "Nursing Unit Administration, first edition", released in June and available from the Nursing Unit Administration Program, 410 Laurier Avenue West, Suite 800, Ottawa, Ontario, K1R 7T6.



And thus, the decision to create a separate entity that would protect and provide for the social and economic welfare of the "labor", as opposed to "management" side of nursing was forced upon the organized profession. Today, the vast majority of registered nurses in these unions are also members of their provincial/territorial associations. Nurses unions and professional associations continue to communicate with each other and, in most provinces, liaison committees have been established to ensure cooperation between the two agencies in the best interests of all nurses.

#### A fraternity of trained professionals

The problem of deciding at what level a nurse becomes management (within the meaning of the labor acts) has plagued employers and provincial labor boards and has resulted in a variety of decisions across Canada. British Columbia, New Brunswick and Prince Edward Island include all positions except director and assistant director of nursing; Alberta, Saskatchewan, Manitoba, Nova Scotia and Newfoundland include head nurses in their bargaining units. Québec has two separate units, one including general staff nurses and assistant head nurses, and a second including head nurses and supervisors. In Ontario panels of the Labor Board have handed down awards that include supervisors in a few units, head nurses in others, with the majority including assistant head nurses and general staff nurses only.

Registered nurses may belong to both the union and professional association. They each function under separate legislation and are autonomous in their own right. With exception of the Registered Nurses Association of

Ontario, each registered nurses association has the legal right to discipline its own members. If a nurse is dismissed or suspended for disciplinary reasons she may be reported to her professional association and if just cause is found her registration/license can be revoked or suspended. The nurse who is also a union member has the right to grieve her dismissal or suspension through to arbitration, and the union under the labor laws must process her grievance. If the arbitration board re-instates the nurse and the professional association revokes her registration, a problem obviously arises, since both the award of the arbitration

board and the action of the disciplinary committee are binding under law. In a situation such as this, it is important that the management-nurse have full knowledge of the relevant legislation and understand fully her role in labor relations. ♦

*Glenna Rowsell is director of Labor Relations Services for the Canadian Nurses Association. She was formerly employment relations officer for New Brunswick's Provincial Collective Bargaining Council and consultant in social and economic welfare for the New Brunswick Association of Registered Nurses.*

**NURSES UNIONS** have now assumed the major responsibility for advancing the socio-economic welfare of the members they represent — approximately 85,000 across Canada. The prime responsibility of these unions is to regulate relations between the employees and employers through:

- negotiating collective agreements providing particularly for improvements in salaries, hours of work, medical welfare benefits and working conditions
- promoting and understanding of administration of collective agreements
- processing grievances including grievance arbitration
- educating members in the area of labor relations and labor legislation
- assisting members with problems arising in a work setting related to the practice of the nurse's profession
- communicating with its members, professional associations, government and general public
- promoting and maintaining professional standards of care as developed by the professional nurses associations
- striving to improve practice settings to allow for the achievements of these standards
- ensuring fair representation of all the employees under the jurisdictions of the unions
- protecting the health and safety of nurses in their working environments.

Most registered nurses who belong to a union are also members of their provincial/territorial professional association. Not all union members are registered nurses, however, since under the terms of their certification some unions are required to represent graduate nurses.

One of the major roles of **THE PROFESSIONAL ASSOCIATION** is the improvement of practice through standards of selection, preparation and performance of practitioners. It is usually the licensing authority with the right to discipline members who do not meet acceptable standards of practice. It meets the needs of the public and its members by:

- providing and influencing continuing education programs for nurses
- ensuring competency to practice
- presenting an informed voice to effect change
- acting as spokesman for the nursing profession with government and other organizations and groups
- protecting the safety of the public
- seeking desirable changes in legislation
- promoting research and studies in nursing
- communicating with members through meetings, conferences, newsletters and the media
- collaborating with other health organizations engaged in health care
- developing social and economic welfare programs for its members
- developing a code of ethics to maintain standards of performance
- encouraging its members to develop new and improved skills to retain and improve their knowledge and practice.

All provincial/territorial nurses' associations are members of the Canadian Nurses Association and the International Council of Nurses; each level of organization supplements the other by extending its sphere of influence.

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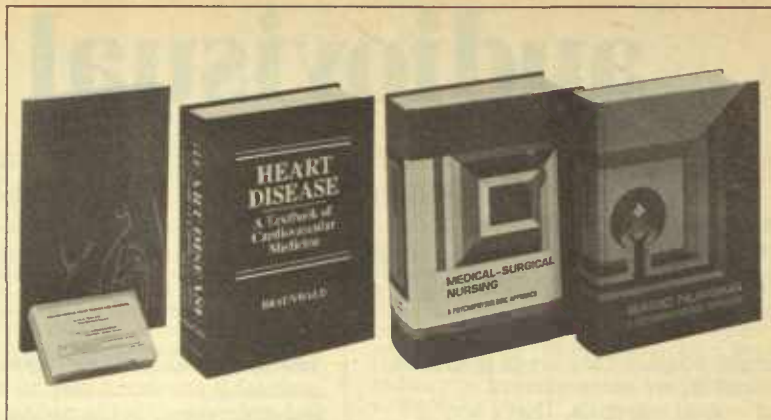
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Joyce Carver

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Having gone through the reviews and made a choice of suitable A/V materials, you are now ready to preview them. The following checklist should help you in this process:

**Content quality:** is the content accurate, comprehensive, impartial and current? is the context and level suited to the intended audience? does it deal in specific facts and procedures or principles and broad concepts? can it be adapted for use in various settings?

**Instructional quality:** are the objectives stated? does it meet them? is an instructor's guide or student manual included? does it observe basic principles of learning, i.e. provide an overview and summary, use simple-to-complex presentation, reinforce important points, and involve the learner by questions and practice exercises?

**Technical quality:** is narration clear and concise? is the sound easy to listen to and understand? is the pacing right for the material? is the photography well composed and varied? are colors bright with good contrast? are titles and graphics easy to read and understand? are slides and filmstrips numbered with manual advance control for reviewing specific parts of the program?

**Cost effectiveness:** can it be used with different levels of learners? will it be useful for individual learning and group presentation? will it become outdated quickly? is the equipment available to use this A/V form? how often will it be used and by how many learners? what is rental vs. purchase cost?

Answering these questions should help you make a good decision based on quality and cost. And don't forget, keep a record of your evaluations on file.

### Recommended reading

- 1 Koch, Harriett. Production and technical standards. *Nursing Outlook* 23:5:287; 1975 May.
- 2 Lange, Crystal M. Availability and cost of media. *Nursing Outlook* 25:3:164; 1977 Mar.
- 3 Sparks, Susan M. AVLINE for nursing education and research *Nursing Outlook* 27:11:733-737; 1979 Nov.



Joyce Carver, RN (P.E.I. Hospital), BN (Dalhousie) received a Master's Degree in Educational Media and Technology from Boston University in 1979. She is an assistant professor at Dalhousie University School of Nursing in Halifax, where she has been involved with A/V affairs since 1975. Previous experience includes work as a community health nurse in P.E.I. and Vancouver.

## McMaster University Educational Program For Nurses In Primary Care

McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

**Requirements** Current Canadian Registration. Preceptorship from a medical practitioner. At least one year of work experience, preferably in primary care.

For further information write to:

Director  
Educational Program for Nurses  
in Primary Care  
Faculty of Health Sciences  
McMaster University  
Hamilton, Ontario L8S 4J9

## The Ups and Downs of Blood Sugar

A color poster entitled "The Ups and Downs of Blood Sugar" has been developed by the Canadian Diabetes Association. The 19 x 24 inch poster depicts the causes of high and low blood sugar by using seven color illustrations. Each illustration includes cartoon figures personifying insulin, exercise and food. The figures are strategically placed on a see-saw that moves up and down to demonstrate changes in blood sugar level caused by changes in the amount of insulin, exercise and food.

This teaching tool is intended for use with both children and adults. The poster sells for \$3.50 and is available from:

The Canadian Diabetic Association  
123 Edward Street, Suite 601  
Toronto, Ontario M5G 1E2

Immediate openings for qualified RN's on all shifts, full time, part time. 203 bed JCAH accredited acute care hospital, adjacent to Oregon Institute of Technology, offering a 2+2 AD/BSN program. We are located in Southern Oregon. Excellent year 'round outdoor activities. Family oriented community. Excellent working conditions and benefits. Competitive salary with opportunity for advancement. Contact Personnel Department, MERLE WEST MEDICAL CENTER, 2865 Daggett St., Klamath Falls, OR 97601, or call COLLECT (503) 882-6311, Ext. 131. We are an equal opportunity employer.



# Classified Advertisements

## Alberta

R.N.'s required. Registered nurses required for new Brooks Health Centre, complex of 70 beds, 15 bassinets, 75 nursing home beds. Centrally located in Southern Alberta between three large cities. Salary as per Provincial Agreement. Must be eligible for registration with AARN. Apply in writing to: Director of Nursing, Brooks Health Centre, Bag 300, Brooks, Alberta T0J 0J0.

Registered Nurses required for a 560-bed acute care hospital in Edmonton, Alberta. Positions available in most clinical areas. Candidates must be eligible for registration in Alberta. Current salary rates under review. Apply to: Personnel Department, Edmonton General Hospital, 1111 Jasper Avenue, Edmonton, Alberta T5K 0L4.

Registered Nurses. We invite you to join our Health Care Team at the Fort McMurray Regional Hospital which is expanding from a 75-bed hospital to a 300-bed hospital. We will provide you with a challenging professional opportunity as a primary nurse involved in our high level patient care programs. Good employee benefits, salary as per the Collective Agreement and registration as per the A.A.R.N. Please contact: Human Resources, Fort McMurray Regional Hospital, 7 Hospital Street, Fort McMurray, Alberta T9H 1P2, (403) 743-3381, ext. 19.

Required—Full-time and part-time Registered Nurses to rotate all three shifts in Active Treatment 66-bed hospital. Apply to: Director of Nursing, Taber General Hospital, Box 939, Taber, Alberta T0K 2G0.

## British Columbia

Experienced General Duty Graduate Nurses required for small hospital located N.E. Vancouver Island. Maternity experience preferred. Personnel policies according to RNABC contract. Residence accommodation available \$30 monthly. Apply in writing to: Director of Nursing, St. George's Hospital, Box 223, Alert Bay, British Columbia V0N 1A0.

General Duty Nurses required for 30 bed accredited hospital. Salary according to RNABC Contract. Apply: Administrator, Chetwynd General Hospital, Box 507, Chetwynd, British Columbia V0C 1J0. (604) 788-2236/2568.

General Duty Nurses for modern 41-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, P.O. Box 60, Fort Nelson, British Columbia V0C 1R0.

General Duty Nurse for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurse's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia V0H 1H0.

## British Columbia

General Duty Registered Nurses required for 108-bed accredited hospital in northwest B.C. Previous experience desirable. Salary as per RNABC Contract with northern allowance. For further information, please contact: Director of Nursing, Kitimat General Hospital, 899 Lahakas Blvd. N., Kitimat, B.C. V8C 1E7.

Registered and Graduate Nurses required for 34 bed acute care hospital located 240 miles North of Vancouver. Accommodation available. Apply to: Director of Nursing, Lillooet District Hospital, Box 249, Lillooet, British Columbia V0K 1V0.

Two Registered Nurses required for a 21-bed general hospital located in the beautiful Robson Valley, 100 miles West of Jasper, Alberta. Rotating shifts, full or part-time work available. Accommodation available for single person. Salary as per RNABC Collective Agreement. Apply immediately to: Director of Nursing, McBride & District Hospital, Box 128, McBride, British Columbia V0J 2E0 or telephone: 604-569-2662.

General Duty R.N.—Small hospital in scenic West Kootenays of B.C. Apply: Slocan Community Hospital, Box 129, New Denver, British Columbia V0G 1S0.

Experienced Nurses (B.C. Registered) required for a newly expanded 463-bed acute, teaching, regional referral hospital located in the Fraser Valley, 20 minutes by freeway from Vancouver, and within easy access of various recreational facilities. Excellent orientation and continuing education programmes. Salary—1979 rates—\$1305.00-\$1542.00 per month. Clinical areas include: Operating Room, Recovery Room, Intensive Care, Coronary Care, Neonatal Intensive Care, Hemodialysis, Acute Medicine, Surgery, Pediatrics, Rehabilitation and Emergency. Apply to: Employment Manager, Royal Columbian Hospital, 330 E. Columbia St., New Westminster, British Columbia V3L 3W7.

Experienced Nurses (eligible for B.C. Registration) required for full-time positions in our modern 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC Contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia V3L 5E8.

Experienced General Duty Nurses required for 130-bed accredited hospital. Salary in accordance with RNABC Contract. Residence accommodation available. Apply in writing to: Director of Nursing, Powell River General Hospital, 5871 Arbutus Avenue, Powell River, British Columbia V8A 4S3.

Registered Nurses required for permanent full-time position at a 147-bed fully accredited regional acute care hospital in B.C. Salary at 1979 RNABC rate plus northern living allowance. One year experience preferred. Apply: Director of Nursing, Prince Rupert Regional Hospital, 1305 Summit Avenue, Prince Rupert, British Columbia V8J 2A6. Telephone (collect) 604-624-2171 Local 227.

## British Columbia

Registered Nurses required immediately for permanent full time positions at 10-bed hospital in B.C. Salary at 1978 RNABC rate plus northern living allowance. Recognition of advanced or primary care education. One year experience preferred. Apply: Director of Nursing, Stewart General Hospital, Box 8, Stewart, British Columbia V0T 1W0. Telephone: (604) 636-2221 Collect.

O.R. Head Nurse required for an active 103-bed acute care hospital. Must be eligible for B.C. Registration. Post graduate training & experience necessary. R.N.A.B.C. Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

General Duty Nurses required for an active, 103-bed hospital. Positions available for experienced R.N.'s and recent Graduates in a variety of areas. RNABC Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

Registered Nurses—Full-time and casual relief positions are available at the University of British Columbia, Health Sciences Centre, Extended Care Unit. The 12 hour shift, the problem oriented record charting system, an emphasis on maintaining a normal and reality based clinical environment and an interprofessional approach to management are some of the features offered by the Extended Care Unit. Interested applicants may enquire by calling 228-7025 or 228-7000. Positions are open to both male and female applicants.

## Manitoba

Registered nurses required for a fully accredited 100-bed general hospital and a 72-bed personal care home located in northern Manitoba. Must be eligible for registration in Manitoba. Salary dependent on experience and education. For further information contact: Mrs. Mona Seguin, Personnel Director, St. Anthony's General Hospital, The Pas Health Complex Inc., P.O. Box 240, The Pas, Manitoba R9A 1K4; or phone collect to: 1-204-623-6431, Ext. 179.

## Northwest Territories

The Stanton Yellowknife Hospital, a 72-bed accredited, acute care hospital requires registered nurses to work in medical, surgical, pediatric, obstetrical or operating room areas. Excellent orientation and inservice education. Some furnished accommodation available. Apply: Assistant Administrator-Nursing, Stanton Yellowknife Hospital, Box 10, Yellowknife, N.W.T., X1A 2N1.

## Ontario

Looking For A Temporary Change? Do you want to keep your job but feel the need for some renewing experience? International registry for nurses interested in a temporary job exchange under organization. Write: Nursing Job Exchange, Box 1502, Kingston, Ontario K7L 5C7.



## United States

**Nurses—RNs—Immediate openings in California-Florida-Texas-Maryland-Virginia and many other States—if you are experienced or a recent Graduate Nurse we can offer you positions with excellent salaries up to \$20,000 per year plus all benefits. Not only are there no fees to you whatsoever for placing you, but we also provide complete Visa and Licensure assistance at also no cost to you. Write immediately for our application even if there are other areas of the U.S. that you are interested in. We will call you upon receipt of your application in order to arrange for hospital interviews. You can call us collect if you are an RN who is licensed by examination in Canada or a recent graduate from any Canadian School of Nursing. Windsor Nurse Placement Service, P. O. Box 1133, Great Neck, New York 11023 (516) 487-2818.**

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## United States

**The Best Location in the Nation — The world-renowned Cleveland Clinic Hospital is a progressive, 1030-bed acute care teaching facility committed to excellence in patient care. Staff Nurse positions are currently available in several of our ICU's and 30 departmentalized medical/surgical and specialty divisions. Starting salary range is \$14,789 to \$17,056, plus \$1,248/year ICU differential and premium shift differential, comprehensive employee benefits and an individualized 7 week orientation. We will sponsor the appropriate employment visa for qualified applicants. For further information contact: Director-Nurse Recruitment, The Cleveland Clinic Hospital, 9500 Euclid Avenue, Cleveland, Ohio 44106 (4 hours drive from Buffalo, N.Y.); or call collect 216-444-5865.**

## Ontario

**Registered Nurses required for our ultra modern 70-bed fully accredited general hospital in a bilingual community of Northern Ontario. Applicants should be registered or eligible for registration with the College of Nurses of Ontario. Knowledge of both official languages and experience in nursing are assets but not essential. Salary is according to the O.M.A. schedule and fringe benefits include one month of holidays, OHIP, salary and life insurance and a drug and dental plan. Assistance is also provided in locating suitable living accommodations. Forward your application to: Personnel Director, Notre Dame Hospital, P.O. Box 8000, Hearst, Ontario POL 1N0. Telephone: (705) 362-4291.**

**Experienced registered nurses are required immediately for our fully accredited thirty-two bed complex and active treatment hospital located in beautiful Northern Ontario. The hospital pays 100 percent OHIP and Dental Plan and many other excellent fringe benefits. Apply to: The Director of Nursing, Homepayne Community Hospital, Homepayne, Ontario POM 1Z0.**

**Registered Nurses required. Hospitals located on James Bay at Attawapiskat and Fort Albany. Good salary scale plus Northern Allowance. Accommodations provided. Enjoy a Northern Experience. For further information, contact: The Administrator, James Bay General Hospital, P. O. Box 370, Moosonee, Ontario POL 1Y0.**

**R.N. Grad or R.N.A., 5'6" or over and strong, without dependents. Non-smoker for 180 lb. handicapped retired executive with stroke. Able to transfer patient to wheelchair. Live-in 1/2 year in Toronto, 1/2 year in Miami. Wages \$250.00 to \$300.00 weekly NET plus \$100.00 weekly bonus on most weeks in Miami. Write: M.D.C., 3532 Eglinton Avenue West, Toronto, Ontario M6M 1V6.**

## Saskatchewan

**Director of Nursing for St. Joseph's Union Hospital, a 22-bed acute care facility. Position available June 30, 1980. Applications are invited from those with appropriate experience and education. Apply with complete resume to the: Administrator, St. Joseph's Union Hospital, Lestock, Saskatchewan S0A 2G0.**

**Applications are invited for the position of General Duty Nurse in a new 22 bed hospital which will be opening in June, located in the beautiful rural north-western Saskatchewan. Salaries, fringe benefits, etc. as per S.U.N. Agreement. Apply or phone: Margarete Lathan, Director of Nursing, Paradise Hill Union Hospital, Box 179, Paradise Hill, Saskatchewan S0M 2G0. (306) 344-2255.**

**University of Saskatchewan-College of Nursing invites applications for the position of Principal Nurse Researcher with faculty status. This position is available immediately. The major responsibility of the appointee is to develop and direct a Nursing Research Unit based at the University of Saskatchewan and supported by the Saskatchewan Registered Nurses' Association. The purpose of this new Research Unit is to facilitate the growth of nursing research; develop nurse researchers and provide for continuity and coordination of nursing research projects to influence the delivery of nursing care in the province. Involvement in this new joint project is a unique opportunity for a nurse researcher seeking a challenge. Qualifications: Doctoral preparation preferred; Masters' degree essential. Eligible for registration with the S.R.N.A. Experience in carrying out applied research related to complex issues in the nursing component of the health care system. Salary: In accordance with university policy and the rank for which the candidate is qualified. Applications and inquiries: Address all inquiries to: The Dean, College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan, Canada S7N 0W0.**

# Choose a Nursing Career in Canada's Ocean Playground



The Victoria General Hospital, Halifax, Nova Scotia is the Maritime's largest teaching hospital. Close association with Dalhousie University and our own extensive continuing education program provide excellent opportunities for learning and career development.

Halifax is an attractive place to work and play. It is the capital city of a Province offering a quality of life which is a careful blend of scenic lifestyle and modern development boasting cultural, recreational and educational facilities second to none.

The Victoria General Hospital offers a variety of nursing specialties for experienced people looking for a professional environment and challenge. Victoria General Nurses have full civil service benefits.

- **GENERAL DUTY NURSES** work in our 28 general nursing units, each of which have specific sub-specialties in Medicine and Surgery.
- **INTENSIVE CARE NURSES** are part of five specialized units such as Coronary, Cardiovascular, Medical, Surgical and Neurosurgery.
- **SPECIALTY AREA NURSES** work in the Burn Unit, Renal Unit, Emergency, Operating Room, Recovery Room or Out-Patients.
- **NURSING ADMINISTRATION.** We encourage promotion through an on-going program of leadership development.

Please quote Competition Number: 80-310.  
For details on nursing opportunities contact:

Mrs. Betty Elliot, R.N.  
Personnel Department, Victoria General Hospital  
5788 University Avenue  
Halifax, Nova Scotia B3H 1V8

Telephone: 1 (902) 428-3484





## United States

**RN/Staff & Management Positions—Kaiser-Permanente**, the country's largest Health Maintenance Organization, currently has excellent opportunities available in our 583-bed Los Angeles Medical Center. Located 7 miles from downtown Los Angeles, close to many of California's finest Universities, this teaching hospital offers RN's a unique chance to further their careers in such areas as: OR, Med/Surg, Maternal Child Health & Critical Care. Management positions are also available. Kaiser offers an attractive array of fringe benefits including relocation assistance, full medical, dental & health coverage, continuing education advanced training available in the Nurse Practitioner & CRNA Programs, individualized orientation, tuition reimbursement, and no rotating shifts. New graduates are always welcome and encouraged to inquire. For more information, please write or call collect: Ann Marcus, RN, Kaiser Hospital/Sunset, 4867 Sunset Blvd., L.A., California 90027. (213) 667-8374.

**California**—Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, Ext. 1680.

**RN'S**—Our Florida hospitals need you! Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. **No Fees!** Call or write: Medical Recruiters of America, 3421 West Cypress St., Tampa, Florida 33607 (813) 872-0202.

**R.N.s**—Experienced nurses needed to staff midwestern and eastern United States hospitals. Must be able to take and pass State boards tests. Free housing while working in United States. Full sponsorship available. Wages begin at \$7.00 per hour. Fulltime. Send resume to: Bonnie Meneses Smith, R.N. Recruiter, JANNA Medical Systems, Inc., 1810 Craig Road, St. Louis, Missouri 63141.

**Registered nurses to work in Texas.** Qualifications: Nursing registration since 1970. No exams necessary for Texas. Experience in OR, Emergency, Pediatrics, Neurology or other areas desired. Available in 1-2 months. No cost to candidates. We handle everything. For information: VISA CONSULTANT of America Inc., 1 Place Ville Marie, Suite 3235, Montreal, Quebec, Canada H3B 3M7. Telephone: (514) 467-1209.

## Miscellaneous

**Adventure Holidays:** Camping Safaris, Overland Expeditions and Fun Experiences. We offer trips from one week to 3 months in: Canada, USA, Europe, Africa, Asia, South and Central America, Australia, New Zealand and the Caribbean. For FREE catalogue, contact your travel agent, or apply to: Goway Travel, 53 Yonge St., Suite 101, Toronto, Ontario M5E 1J3. Phone: 416-863-0799. Telex: 06-219621.

## Australia

**Faculty Positions** available in undergraduate instruction in Medical-Surgical Nursing and in a Baccalaureate program designed for Registered Nurses in the area of Nursing Administration. Both are dynamic programs. The School of Nursing has a student enrolment of over 300. Salary commensurate with qualifications and experience: Lecturer 11—A\$17,024-19,645 per annum; Lecturer 1—A\$19,923-22,362 per annum. Preference: Master's degree; teaching and clinical experience; knowledge of curriculum development. The Institute has allowance schemes covering re-location expenses, immediate superannuation, insurance cover and assistance with accommodation. Closing date for applications: three weeks after publication of this advertisement. Appointees are expected to take up duties as soon as possible. Curriculum vitae and transcripts of tertiary work to: Lydia Hebestreit, R.N., Head: School of Nursing, Preston Institute of Technology, Bundoora/Melbourne, 3083, Australia.

**Before accepting any position in the U.S.A. PLEASE CALL US COLLECT**  
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**BCIT** BRITISH COLUMBIA  
INSTITUTE OF TECHNOLOGY

## DEAN HEALTH DIVISION

BCIT is a major post-secondary institution, located in Burnaby, with a mandate to serve the entire province of British Columbia in two-year diploma programs in the areas of health, business and engineering. The nine diploma programs which the health division comprises of are: Biomedical Electronics, Environmental Health, Medical Laboratory, Medical Radiography, Nuclear Medicine, Health Data, General Nursing, Psychiatric Nursing and Prosthetics and Orthotics. There are 85 instructors, 7 department heads and a student enrolment of about 900. The total full-time student enrolment at BCIT is 4,000.

The dean will be accountable to the vice principal of education, for the provision of responsive and effective educational programs in the health field and for the personnel, financial and operational control of the division. Considerable interaction and consultation with advisory committees, accreditation bodies, professional organizations and the provincial government will be required.

The successful candidate will possess wide experience in the health care field with a solid background of strong administrative capabilities. Also the candidate must have a proven ability to carry out a liaison role with senior levels of government and health care organizations.

**Closing date for applications: July 1, 1980**

**Submit resume in strict confidence to Personnel/Labor Relations Office**

**British Columbia Institute of Technology  
3700 Willingdon Avenue, Burnaby, B.C.  
V5G 3H2, Phone (604) 434-5734**



## Prince George Regional Hospital

Positions available for experienced nurses or nurses interested in developing their skills in specialty nursing — Operating Room, ICU/CCU, Neonatology Nursing. Must be eligible for B.C. Registration.

- Well developed orientation program
- Inservice Education
- Expanding Operating Room and Obstetrical Suite
- 10 bed ICU/CCU

Prince George Regional Hospital is a 340 bed acute regional referral hospital with a 75 bed extended care unit and has a planned program of expansion.

For further information contact the:

**Personnel Department**  
Prince George Regional Hospital  
2000 - 15th Avenue  
Prince George, British Columbia  
V2M 1S2

## Royal Jubilee Hospital Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

**Director of Nursing**  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

OPPORTUNITY

Alberta

## Senior Community Mental Health Nurse - Fort McMurray

We require an experienced nurse for a multi-disciplinary treatment team. You will supervise community psychiatric nurses, consult and act as educator to other therapists caseloads, assume a limited caseload, evaluate staff performance, and consult with the clinic director on effective service objectives.

Qualifications: Graduation from a recognized school of nursing, considerable related experience and eligibility for registration with the appropriate nursing association.

Salary: \$16,608 - \$20,604 plus  
Northern Allowance.  
Competition #9186-4

## The Izaak Walton Killam Hospital for Children

### Assistant Head Nurse Neo-Natal

The I.W.K. Hospital for Children requires an Assistant Head Nurse for our Neo-Natal Unit, which is a 32-bed referral centre providing intensive, intermediate and convalescent care.

Applicants must be a graduate of an accredited School of Nursing and eligible for registration in Nova Scotia. Degree or Diploma in Nursing Service Administration is preferred. Must have a good knowledge of Neo-Natal nursing principles and techniques.

Inquiries and applications should be directed to:

**Karen Lyle, Personnel Officer**  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
B3J 3G9

## Psychiatric Nurses

required

For regional hospital. Primary duties to include provision of nursing service in "day hospital", mental health centre and the community.

Applicants should have (or be eligible for) current registration in Province. Post graduate training in psychiatric nursing preferred but equivalent combination of training and experience will be considered.

Applications to:

**Personnel Office**  
Highland View Regional Hospital  
110 East Pleasant Street  
Amherst, Nova Scotia  
B4H 1N6

## Community Mental Health Nurses - Athabasca/Slave Lake Area & Edmonton

We require nurses to provide assessment, treatment and follow-up as primary therapists of a multi-disciplinary team. Other duties include provision of services to community and liaison and consultation with agencies.

Qualifications: Graduate of a recognized school of nursing and eligible for nursing registration in Alberta and some related experience. NOTE: Must own transportation and a valid Alberta drivers license.

Salary: \$14,748 - \$17,340  
Competition #9184-5 Open until  
suitable candidates selected. Please  
indicate location preference on  
application form.

For detailed information, request  
Job Bulletins and apply to:

**Alberta Government Employment Office**  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4

## Registered Nurses

Registered Nurses are required for an 87 bed accredited Hospital in Northern Ontario.

Applicants must be eligible for Registration with the College of Nurses of Ontario.

Bilingualism is an asset.

Salary and Fringe Benefits in accordance with O.N.A. Contract.

Temporary residence accommodation is available.

Please apply in writing to:

**Director of Nursing**  
Sensenbrenner Hospital  
10 Drury Street  
Kapuskasing, Ontario  
P5N 1K9

## Camp Hill Hospital

a fully accredited 350 bed active care teaching facility in beautiful Halifax, N.S., is currently inviting applications for the position of:

### Head Nurse, Operating Room

If you are eligible for registration in the province of Nova Scotia, have previous experience in an Operating Room with demonstrated skills in leadership and interpersonal relationships, and post-graduate Operating Room Training, then we are looking for you.

Our hospital, centrally located in Canada's Ocean Playground, provides progressive care in medical, surgical, psychiatric, and extended care areas.

Salary range:  
presently - \$15,300 to \$17,200  
eff. 1/10/80 - \$16,000 to \$17,900

plus additional educational premiums  
If you are interested in joining our staff, please apply in writing to:

**Staffing Officer**  
Camp Hill Hospital  
1763 Roble Street  
Halifax, Nova Scotia  
B3H 3G2



## Registered Nurses

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Recruiting Registered Nurses Inc. We're the Canadian  
Medical Placement Specialists throughout the United  
States.

R.R.N. has immediate positions available in:

California — Ohio — Pennsylvania — Michigan

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information.

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RECRUITING REGISTERED NURSES INC.



1200 Lawrence Avenue East  
Suite 301, Don Mills  
Ontario M3A 1C1  
Telephone: (416) 449-5883

## Ministry of Health

### Community Nurses

Competition H80:1150-98 \$18,768 - \$22,176

Applications are invited from qualified persons to form an  
Eligibility List (valid for six months) of community nurses from  
which vacancies occurring at various locations in British  
Columbia will be filled.

Duties include provision of general public nursing, counselling  
and crisis intervention services in the area concerned; liaison  
with health professionals and others providing care, and  
encouragement of appropriate use of available facilities.

Qualifications - University degree in nursing, including public  
health training, or equivalent combination of education and  
experience; preferably some general nursing experience,  
including directly related duties; registered, or able to obtain  
registration, in the Registered Nurses and/or Registered  
Psychiatric Nurses Association of British Columbia. May use  
own or government car on expenses.

Return applications immediately.



Province of British Columbia  
Public Service Commission

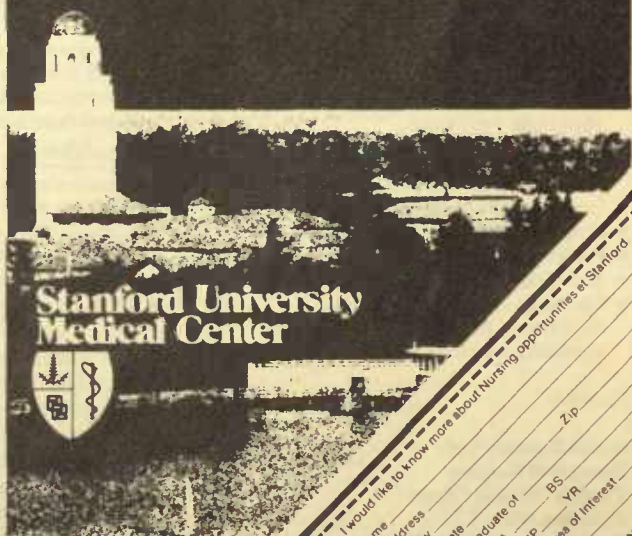
Positions  
are open to both  
men and women.  
Obtain applications from,  
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544 Michigan Street, Victoria, B.C., V8V 1S3

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Stanford University Hospital,  
Stanford, CA 94305. Or call collect to:  
**(415) 497-7330**. For immediate  
consideration, send your resume and  
salary requirements. We are an  
affirmative action, equal opportunity  
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Stanford University  
Medical Center

I would like to know more about Nursing opportunities at Stanford

Name	Address	City	State	Graduate of	AA	DIP	BS	YR	Area of Interest	CA433
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Foothills Hospital  
Calgary, Alberta  
Offers the  
Following  
Five Month Post  
Graduate Courses



### Advanced Neurological & Neurosurgical Nursing

This course serves as an extension of basic knowledge of neurological problems gained in an under graduate program. Instruction proceeds from normal to abnormal. Opportunities are provided to study and care for persons of all ages who have had an interruption in neurological function.

### Advanced Neonatal Nursing

This course allows the nurse to gain knowledge and expertise in the Intensive Care Nursery setting. An overview of life as well as experience in related settings are also included.

Applications must be completed three months prior to the enrollment dates of March and September.

For information and application write to:  
Educational Services  
Department of Nursing  
Foothills Hospital  
1403 - 29th St. N. W.  
Calgary, Alberta T2N 2T9

### Drumheller Health Unit requires Community Health Nurse

Position available approximately September 30, 1980.

#### Qualifications:

Registered Nurse with Diploma in Public Health or a B.Sc. degree. Experience in Community Health is desirable. Applicant must have valid driver's license, and be eligible for registration in Alberta.

#### Salary:

Commensurate with qualifications and experience (presently under review) and excellent fringe benefits.

Applications with curriculum vitae to:

Dr. A.E. O'Neill  
Medical Officer of Health  
Drumheller Health Unit  
P.O. Box 1780  
Drumheller, Alberta  
T0J 0Y0

### Registered Nurses

### Cross Cancer Institute

### Edmonton

Our Institute has immediate openings for Staff Nurses who are interested in progressive nursing as members of a dynamic multi-disciplinary health care team. We offer challenging and rewarding nursing, job security, continuing education, and excellent fringe benefits.

For additional information and details, please call collect or write:

Mary James  
Nursing Co-ordinator  
11560 University Avenue  
Edmonton, Alberta  
T5G 1Z2  
Phone (403) 432-8771

### R.N.'s Required

Applications are invited for full time nurses to work rotating shifts in new 40 bed active treatment hospital. High level of activity in Emergency, Surgery and Obstetrics offers challenge and the benefit of valuable experience for conscientious nurses. Previous experience an asset. Must be registered or eligible for registration in Alberta.

AHA/AARN Policies in effect.

Hinton is a modern, progressive, industrial town on the eastern slopes of the Rockies, 50 miles east of Jasper. Population 7,600. Unlimited year round recreational facilities.

Apply with full resume including experience and references to:

Director of Nursing  
Hinton General Hospital  
Box 40  
Hinton, Alberta  
T0E 1B0

### Selkirk College

### Castlegar, B.C. requires an Instructor Allied Health (Nursing)

#### Duties:

Classroom instruction and clinical teaching of nursing to students in a diploma nursing program.

#### Qualifications:

Baccalaureate degree, including courses in nursing and education. Practicing registration or eligibility for registration as a nurse (R.N.) in B.C. is desirable; appropriate clinical experience (2 year's minimum). Master's degree preferred.

Starting Date: July 1, 1980 Application Closing Date: May 30, 1980

#### Salary:

Commensurate with qualifications and experience with the faculty agreement.

Submit Applications and References To:  
Personnel Manager  
Selkirk College  
Box 1200  
Castlegar, B.C.  
V1N 3J1

### Head Nurse

Royal Inland Hospital, a 400-bed acute care regional referral hospital, invites applications for:

Head Nurse in the Emergency and Out Patients Department. This is a 14 stretcher 2 crib Emergency Department.

Qualifications: preferably a nursing degree and 3 - 5 years experience with demonstrated administration skills and clinical expertise or NUA course with relevant experience. Must be eligible for B.C. registration. Rate per R.N.A.B.C. contract.

Please send resume to:

Personnel Office  
Royal Inland Hospital  
311 Columbia Street  
Kamloops, British Columbia  
V2C 2T1

### R.N.'s

#### Come to Texas

- 244 Bed Regional Medical Center
- Located 75 miles north of Dallas on the banks of Lake Texoma (12th largest lake in the U.S.)
- Progressive Nursing Administration
- Professional growth opportunities
- Excellent salary and benefits program
- Openings in ICU, Emergency, Psychiatry, Renal Dialysis, and other speciality areas

Contact:

Bonita Palmer, R.N.  
Director of Nursing  
Texoma Medical Center  
P.O. Box 890  
Denison, Texas, USA 75020

### Head Nurse—Paediatrics

The Prince George Regional Hospital, a 340 bed acute care and 75 bed extended care hospital, requires a Head Nurse for a 30 bed Paediatric Surgical Unit.

#### Requirements:

- Demonstrable leadership and administrative skills.
- Clinical preparation and previous experience in the care of the Paediatric surgical patient.
- Must be eligible for registration in B.C.

Salary Range: In accordance with the R.N.A.B.C. Contract.

Interested applicants are invited to submit applications to the:

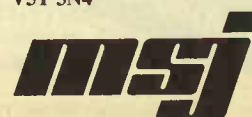
Personnel Department  
Prince George Regional Hospital  
2000—15th Avenue  
Prince George, British Columbia  
V2M 1S2

### Registered Nurses

300 bed Accredited general hospital in Vancouver requires full-time, part-time and casual R.N.s for general duty and ICU nursing. Candidates should be eligible for registration in B.C. Recent nursing experience preferred. ICU candidates must have previous ICU experience.

Please apply to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C.  
V5T 3N4





Association of Registered Nurses of Newfoundland

### Executive Secretary—Director

The Association of Registered Nurses of Newfoundland invites applications for the position of Executive Secretary—Director.

The applicant must have a comprehensive knowledge of the nursing profession and its role in the health care system, a wide experience in the practice of nursing administration.

Applicants must have had experience in the practice of nursing and administration, have demonstrated leadership ability, ability to initiate and maintain relationships with governments, allied professionals, the members and the public, and be eligible for registration with the Association of Registered Nurses of Newfoundland. A Baccalaureate Degree in Nursing required, a Master's Degree preferred.

Send curriculum vitae by August 31, 1980 to:

Chairman, Selections Committee  
Association of Registered Nurses of Newfoundland  
P.O. Box 4185  
St. John's, Newfoundland  
A1C 6A1

OPPORTUNITY

Alberta

### Senior Community Mental Health Nurse Fort McMurray

We require an experienced nurse for a multi-disciplinary treatment team. Responsibilities include supervision of community psychiatric nurses, consultant and educator to other therapists caseloads, assuming a limited caseload, evaluating staff performance, and consulting with the clinic director on effective service objectives.

**Qualifications:** Graduation from a recognized school of nursing, considerable related experience and eligibility for registration with the appropriate nursing association.

**Salary:** \$16,608—\$20,604 plus Northern Allowance (currently under review).

Competition No.9186-6 Open until suitable candidate selected. Alberta Social Services and Community Health.

For detailed information, request Job Bulletins and apply to:

Alberta Government Employment Office  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4

# A Good Place To Work... A Great Place To Live.



At Santa Clara Valley Medical Center, we recognize the importance of an environment that offers meaningful work and intellectual challenge. We also offer you a great place to live—in Northern California's unique Santa Clara Valley, where you'll find a variety of cultural and geographical attractions.

  
**Santa Clara Valley  
Medical Center**

Caring is our Specialty

We are a fully accredited, acute care, general teaching hospital which includes a government designated rehabilitation center specializing in head trauma and spinal cord injuries. We are offering opportunities for experienced and graduating nurses in the following areas:

<b>Critical Care Unit</b>	<b>Burn Unit</b>	<b>Spinal Cord Injury Unit</b>
<b>Neonatal</b>	<b>Head Injury Unit</b>	<b>Emergency Room</b>
<b>Intensive Care Unit</b>	<b>Medical/Surgical</b>	<b>OB/GYN</b>

To find out more about our excellent benefits, salaries and educational opportunities, fill out and send us the coupon below, or call **Eleanore Abeytia** at (408) 279-5232. We are an equal opportunity employer m/f/h.

Name \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Graduate of: \_\_\_\_\_ BS \_\_\_\_\_ AA \_\_\_\_\_ DIP \_\_\_\_\_  
Year \_\_\_\_\_ Area of Interest \_\_\_\_\_  
Mail to: Eleanore Abeytia, Personnel Department,  
751 S. Bascom, Bg H-6, San Jose, CA 95128. An equal  
opportunity employer m/f/h.

CAN-07



## University of British Columbia

Health Sciences Centre Hospital

Extended Care Unit

requires

### Clinical Nursing Consultant—Education

Reporting to the Director of Nursing, plans and implements orientation and on-going in-service programs for nursing and other staff members, coordinates pre-admission assessment activities, provides direct patient care to selected patients as arranged, facilitates clinical nursing research, participates in School of Nursing activities in the unit as requested, represents E.C.U. in Nursing Education areas and maintains an effective working relationship with nursing and other health professionals. Requires Master's degree in Nursing or Nursing Education, registration with the RNABC, evidence of clinical competence in the care of elderly/disabled patients demonstrated skills in program planning, implementation and evaluation and successful work experience in clinical nursing and nursing education. Salary and benefits according to RNABC collective agreement.

Applicants should submit detailed resume to:

Coordinator of Hospital Employment  
Health Sciences Centre Hospital  
University of British Columbia  
Vancouver, British Columbia  
V6T 1W5

Position open to both male and female applicants.

## International Grenfell Association

requires

### Registered Nurses, Public Health Nurses and Nurse—Midwives (R.N.)

For Northern Newfoundland and Labrador

The International Grenfell Association provides medical services in northern Newfoundland and Labrador. It staffs four hospitals, seventeen nursing stations and many public health units. Our main hospital is a 150 bed accredited hospital situated in scenic St. Anthony, Newfoundland. Active treatment is carried on in surgery, psychiatry, medicine, pediatrics, obs/gyn, and intensive care. Orientation and active inservice program provided for staff. Salary based on government scales, 37-1/2 hrs. per week. Rotating shifts. Excellent personnel benefits include liberal vacation and sick leave. Accommodation available. Return travel expenses paid to Winnipeg and east of Winnipeg on completion of one year service, and west of Winnipeg on completion of two years service.

Apply to:

Mr. Scott Smith  
Personnel Director  
International Grenfell Association  
St. Anthony, Newfoundland  
AOK 4S0

**Home  
is where  
the  
heart is**

Sometimes you have to go a long way to find home. But when you arrive at White Memorial you'll know your heart is in the right place.

**Canadian Nurses DO NOT have to take the screening examination offered by the commission on graduates of foreign nursing schools. Your California license will be issued upon completion of application for license.**

White Memorial is a 377-bed acute care teaching medical center offering diversity and challenge for skilled RNs. Additionally, The White will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. We provide an excellent salary, outstanding benefits and the opportunity to participate in our exceptional continuing education program.

*Call collect or write:*

**Ken Hoover**

*Assistant Personnel Director  
(213) 268-5000 ext. 1680*

## WHITE MEMORIAL MEDICAL CENTER

1720 Brooklyn Avenue / Los Angeles, California 90033

An Equal Opportunity Employer M/F





## VON FOR CANADA

Applications are invited for positions across Canada

### • Registered Nurses

— with at least one year's experience

### • Nurses with BScN or Master's Degree

— experience in supervision and/or administration preferred

Salary commensurate with education and experience

Apply to:

National Director  
VON for Canada  
5 Blackburn Avenue  
Ottawa, Ontario  
K1N 8A2

## Clinical Instructor – Operating Room

Required for a 340 bed acute care hospital and 75 bed Extended Care Unit. Expanding Operating Room suite presently under construction with date of completion September 1980.

Will be responsible to design and implement an education-orientation program for new employees and to provide programs for inservice and continuing education for O.R. personnel.

Salary as per R.N.A.B.C. Contract.

Diploma in Teaching and Supervision required plus minimum of three years progressive experience in Operating Room nursing.

Apply to:

Personnel Department  
Prince George Regional Hospital  
2000—15th Avenue  
Prince George, British Columbia  
V2M 1S2

## The Izaak Walton Killam Hospital For Children

### Staff Nurses

The I.W.K. Hospital for Children has vacancies for Staff Nurses on various units throughout the Hospital. Must be a graduate from an accredited School of Nursing and be eligible for registration in Nova Scotia. Previous pediatric experience would be an asset.

Inquiries and applications should be directed to:

Karen Lyle  
Personnel Officer  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
B3J 3G9

## Registered Nurses

Applications are invited for full time and part time employment at Oshawa General Hospital, a 600 bed hospital, 48 kms. East of Toronto.

Successful candidates must be registered in Ontario.

Services provided include:

Medicine	Paediatrics
Surgery	Intensive Care
Obstetrics	Coronary Care
Emergency	Out-Patients
Chronic/Rehabilitation	

Salary Range: (Full time) \$1,450.00 –  
\$1,676.00 (monthly)

Inquiries may be directed to:

Personnel Services  
Oshawa General Hospital  
24 Alma Street  
Oshawa, Ontario  
L1G 2B9

## OPPORTUNITY Alberta

## Community Mental Health Nurse - Peace River Mental Health Clinic

Working as a primary therapist within a multi-disciplinary team, you will provide treatment services to people of all ages, co-operate with other related agencies, and participate in programs promoting mental health.

**Qualifications:** Graduation from an approved school of nursing plus some related experience in psychiatric or community nursing. Eligibility for registration in the appropriate nursing association.

**NOTE:** Own transportation.

Salary: \$14,748 - \$17,340 (currently under review)

Competition #9184-4 Open until suitable candidate selected.  
Alberta Social Services and Community Health

For detailed information, request Job Bulletins and apply to:  
Alberta Government Employment Office

5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4



## Health Sciences Centre Winnipeg, Manitoba

invite applications for the position of

## Teacher Post-Basic Course in Pediatric Critical Care Nursing

The Children's Hospital of the Health Sciences Centre is a 202 bed accredited referral and tertiary care teaching and research facility for children, which serves Manitoba and surrounding areas.

Individuals must be registered or eligible for registration with the Manitoba Association of Registered Nurses and have post-basic preparation and demonstrated expertise in critical care nursing. Applicants must have experience in pediatric and/or neonatal nursing and have experience in teaching. A Baccalaureate degree in nursing is preferred.

The successful applicant will be responsible for the implementation and coordination of this new course. The course is designed to provide advanced preparation for nurses in the care of the critically ill neonate and child. The duties will include student selection, classroom and clinical teaching within the Critical Care Units of the Children's Hospital.

This position is open to females and males.

Interested persons should submit a resume detailing education and experience to the:

Manager Employment & Training  
Health Sciences Centre  
700 William Avenue  
Winnipeg, Manitoba  
R3E 0Z3



## Interested In Paediatric Nursing ? Toronto, Canada

The Hospital For Sick Children invites applications for all units from experienced nurses interested in working in a paediatric tertiary care setting.

We are a fully accredited 700 bed paediatric teaching hospital affiliated with the University of Toronto located in the thriving environment of downtown TORONTO. A thorough orientation and a variety of continuing education programs is provided. The majority of units operate on a 12 hour shift basis, which normally allows every other weekend off. A comprehensive employee benefit package, including a Dental Plan is offered.

Our philosophy is Family Centred Care.

### Qualifications:

- Current registration with the Ontario College of Nurses or eligibility for registration.
- Recent related experience in an active treatment setting preferred.
- Paediatric experience would be considered a definite asset.

Applicants are invited to contact:



**Dorothy Franchi,**  
Personnel Co-ordinator,  
The Hospital for Sick Children,  
555 University Avenue,  
Toronto, Ontario, Canada M5G 1X8,  
(416) 597-1500 ext. 1675.

## The Hospital for Sick Children

OPPORTUNITY

**Alberta**

### Nurse - Edmonton

Rosecrest Home, cares for physically and/or mentally handicapped infants from birth to 4 years of age. You will examine and admit children, check case histories and arrange for any special care or diet required, prepare and maintain reports and progress charts on the children, supervise nursing aides, and assist with the routine daily child care. Shift work involved.

**Qualifications:** Graduation from an approved school of nursing; experience in professional nursing work, pediatrics preferred. Eligible for registration with the appropriate Nursing Association in Alberta.

Salary: Up to \$18,840 (rates to be revised)

Competition #9185-4 Open until suitable candidate selected.

For detailed information, request Job Bulletins and apply to:

Alberta Government Employment Office  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4

Churchill Health Centre a community-governed comprehensive health and social service facility serving Churchill, the surrounding area of Manitoba and acting as a referral centre for the Keewatin District of the Northwest Territories has an opening for a

## Public Health Nurse

The successful candidate will provide Nursing services and promote the health of individuals and families in the community through program development, teaching, counselling and appropriate rehabilitative methods.

In addition to regular duties as a Public Health Nurse, the successful candidate will be a member of a multi-disciplinary team and must be willing to work flexible hours. A willingness to engage in non-traditional nursing areas and a desire to work with Native people will be an asset. Community Health Workers work alongside the Public Health Nurse as well as workers from Child Welfare, Probation and Alcohol Counselling.

The successful candidate should possess a Baccalaureate Degree in nursing or a Public Health Diploma. The successful candidate also must have a current license to practise as a Registered Nurse in Manitoba.

Salary: commensurate with qualifications and experience.

Fringe Benefits: Northern Living Allowance, 20 days paid annual vacation with removal assistance, inward and outward removal assistance, group life and pension available, and fully modern furnished subsidized housing.

Interested persons should send a detailed resume to:

**Ms. Florence Flynn**  
Director of Outreach  
Churchill Health Centre  
Churchill, Manitoba  
R0B 0E0  
Phone: 204-675-8881, ext. 152





Open to both  
men and women



# NURSES

## Solicitor General of Canada

Salary: Up to \$23,367 (under review)

Ref. No: 80-NCRSO-NU-15

**CLEARANCE NUMBER: 310-106-022**

The Correctional Service of Canada will have positions available at various locations across Canada over the next 12 months in Federal Correctional Institutions and special psychiatric hospitals.

**Salaries:** Up to \$23,367 (under review) - dependent on qualifications, assignment, and location - plus penological factor allowance of up to \$1,000 per annum. (under review)

### Opportunities

Correctional health care and forensic psychiatry provide new and expanding career opportunities for nursing professionals. These unique, challenging areas demand men and women with proficient nursing skills, special personal qualities, and a pioneering spirit.

### Responsibilities

In the Health Care Centres (HCCs), the nurses are the inmates' first contact with health care professionals. Each nurse must be independent, resourceful and prepared to operate in an expanded nursing role. In the Regional Psychiatric Centres (RPCs), the treatment philosophy emphasizes a multi-disciplinary approach encompassing all aspects of psychiatry. The primary therapist in each of these university-affiliated hospitals is frequently the nurse.

### Duties

Assist in the development of medical and psychiatric programmes for inmates in either health care centres or regional psychiatric centres and provide nursing care to patients on a 24 hour basis.

### Benefits

Excellent pension plan; good sick leave benefits; evening, night and weekend premiums; 11 statutory holidays; and a minimum three weeks holiday; continuing education opportunities and relocation expenses.

### Qualifications

- Registered Nursing diploma for HCCs and RPCs
- Registered Psychiatric Nursing diploma for RPCs
- Registered/Certified/Licensed Nursing Assistant diploma for RPCs
- Baccalaureat degree in Nursing an asset for HCCs and RPCs
- Recent general nursing experience required for HCCs
- Recent psychiatric nursing experience required for RPCs
- Administrative and supervisory experience required for managerial positions in HCCs and RPCs

### Language Requirements

For some positions knowledge of both English and French is essential. Because of the nature of these positions bilingual capacity is required immediately. Other positions require a knowledge of English, others a knowledge of French while others require a knowledge of English and French. Unilingual persons may apply for bilingual positions but must indicate their willingness to become bilingual. The Public Service Commission will assess the likely aptitude of candidates to become bilingual. Language training will be provided at public expense.

*"Additional job information is available by writing to the address below;*

*Toute information relative à ce concours est disponible en français et peut être obtenue en écrivant à l'adresse suivante".*

### For further information call (collect) or write:

Director, Nursing Operations  
340 Laurier Avenue West  
Ottawa, Ontario K1A 0P9  
Tel.: (613) 995-4971

### How to apply

Send your application form and/or résumé to:

Mrs. Joyce Bleakney

Public Service Commission of Canada

National Capital Region Staffing Office

L'Esplanade Laurier, West Tower, 16th floor

Ottawa, Ontario K1A 0M7

Closing Date: March 31, 1981

*Please quote the applicable reference number at all times.*



# **HOSPITAL CORPORATION INTERNATIONAL**

## **Interested in a Challenge?**

### **Try International Nursing - In Saudia Arabia**

If you are looking for a change, a chance to travel, some hard work and adventurous living, then you might consider international nursing. You will have not only the opportunity to give — to share your nursing expertise — but the opportunity to receive as well — to learn by living in a completely different culture. Truly, a chance for personal and professional growth.

Available positions include both administrative and staff level nursing. Requirements depend on the position — at staff level a minimum 2-3 years current experience in an acute care hospital or clinic setting. Current R.N. license in one of the Provinces. Single status contracts are offered for 18 or 24 month periods.

Attractive salaries with excellent benefits including air transportation, furnished lodging, generous vacation, bonus pay and bonus leave.

Interested in this once in a lifetime opportunity?  
For more details, please send professional  
resume to:

**Kathleen Langan**  
**Hospital Corporation International, Ltd.**  
**Two Robert Speck Parkway, Ste. 750**  
**Mississauga, Ontario L4Z 1H8**

**An Equal Opportunity Employer**

### **Director of Nursing Acute Care**

Shaughnessy Hospital requires a Director of Nursing for 450 adult acute care beds situated within an 1,100 bed community and teaching facility. Affiliated with the University of British Columbia, we offer medical, surgical and specialty care services.

Reporting to the Director of Patient Services (Nursing) the incumbent will be responsible for the management of acute services.

The successful candidate will possess 5–10 years experience in nursing management and varied clinical experience in acute care. A Master's in Nursing Administration is preferred.

Salary will be commensurate with qualifications and experience.

Please submit resume to:



**Vivian L. Walwyn**  
**Employment Manager**  
**Shaughnessy Hospital**  
**4500 Oak Street**  
**Vancouver, British Columbia**  
**V6H 3N1**

### **Regina General Hospital**

#### **Requires**

#### **Clinical Coordinator**

Under the supervision of the Director, Nursing Services, is responsible for the supervision, coordination and administration of all nursing services in the Operating Room Department.

Position requires successful completion of a Diploma Nursing course and registration with the S.R.N.A.

Three years of O.R. Nursing experience with Post-Basic Operating Room training. Preparation in nursing administration with related experience.

A regeneration program which is in progress includes plans for new facilities for surgical suite covering a wide range of services to be completed in 1983. This challenging position will allow the successful applicant to become involved in all aspects of planning.

Please apply to:

**Personnel Services**  
**Regina General Hospital**  
**Regina, Saskatchewan**  
**S4P 0W5**





## The University Of Lethbridge

invites applications for  
**ASSISTANT OR  
ASSOCIATE PROFESSOR**  
School of Nursing

**QUALIFICATIONS** • Current Canadian Registration. Post-Masters or Masters degree and experience in nursing education and curriculum development at the university level. **Preference will be given to candidates with Community Health or Maternal and Child Health background.**

**RESPONSIBILITIES** • Teaching in the Bachelor of Nursing (Post-RN) degree program. Responsibility for planning, organizing and directing field experiences in community health agencies in Southern Alberta.

**SALARY** • Appointment possible at Assistant or Associate Professor rank, depending upon qualifications.

1979-80 Range: Assistant — \$20,446 to \$28,616  
Associate — \$26,180 to \$37,280

**APPOINTMENT** • Effective as soon as possible, not later than January 1, 1981.

**APPLICATIONS** • Including a curriculum vitae and names of three references should be forwarded to:

Director of Nursing  
University of Lethbridge  
4401 University Drive  
LETHBRIDGE, Alberta T1K 3M4

## Registered Nurses

Come to work in scenic Corner Brook!

Registered nurses are needed for this 350 bed Regional General Hospital, with detached 60 bed Special Care Unit, serving the West Coast of Newfoundland.

The hospital offers good fringe benefits such as four weeks annual vacation and eight statutory holidays plus birthday holiday. In addition there is a hospital pension plan and a group insurance plan for all permanent employees.

Accommodation and assistance with transportation is available.

Negotiated Salary Scale:

1 January, 1979 — \$12,771.00 — 15,429.00  
1 January, 1980 — \$13,410.00 — 16,199.00  
(Contract not yet signed)

Service Credits recognized.

Interested applicants apply to:

Mrs. Shirley M. Dunphy  
Director of Personnel  
Western Memorial Regional Hospital  
P.O. Box 2005  
Corner Brook, Newfoundland  
A2H 6J7

# a little help



## can go a long way

...to the Canadian North in fact!

Canada's Indian and Eskimo peoples in the North need your help. Particularly if you are a Community Health Nurse (with public health preparation) who can carry more than the usual burden of responsibility. Hospital Nurses are needed too... there are never enough to go around.

And challenge isn't all you'll get either — because there are educational opportunities such as in-service training and some financial support for educational studies.

*For further information on Nursing opportunities in Canada's Northern Health Service, please write to:*

Medical Services Branch  
Department of National Health and Welfare  
Ottawa, Ontario K1A 0L3

Name .....

Address .....

City ..... Prov. ....



Health and Welfare  
Canada

Santé et Bien-être social  
Canada



## Toronto Western Hospital

### “The Home Of Friendly Care and Protection”

This 700 bed University Teaching Hospital has employment opportunities for registered nurses, or nurses eligible for Ontario Registration in such areas as:

- Intensive Care
- Renal Dialysis
- Neuro Surgery
- Cardio Vascular Surgery

Planned orientation and on-going education programme in effect.

Apply to:

Miss H. Jones, Staffing Co-ordinator  
Department Of Nursing  
Toronto Western Hospital  
399 Bathurst Street  
Toronto, Ontario  
M5T 2S8

## Nurse Clinician—Pediatrics

This position represents a challenging opportunity for a baccalaureate prepared nurse with experience in teaching and pediatric nursing.

The successful applicant will provide nursing care to a specified group of patients having complex needs and will carry out staff development activities for pediatric nursing staff.

Applicants should be prepared to develop, the Nurse Clinician role in a pilot project over a period of 18 months.

If you're a nurse who enjoys the challenge of patient care and teaching....

Please send resume to:

Mrs. L. Rivers  
Manpower—Nurse Interviewer  
St. Boniface General Hospital  
409 Tache Avenue  
Winnipeg, Manitoba  
R2H 2A6

## Registered Nurses

1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including:

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education Programs.  
Post Graduate Clinical Courses in Cardiovascular—  
Intensive Care Nursing and Operating Room Nursing.

Apply to:

Recruitment Officer — Nursing  
University of Alberta Hospital  
8440 — 112th Street  
Edmonton, Alberta  
T6G 2B7



## University of Alberta Hospital

Edmonton, Alberta



## Registered Nurses

**Are You Looking.....**  
for a challenge in your career?

**Would You Enjoy.....**  
living in Vancouver?  
a salary range of \$1,624.00 - 1,784.00 per month?  
4 weeks vacation, and 100 percent medical-dental premiums?  
1 week orientation or longer for specialty areas?

### If So Read On!....

Shaughnessy Hospital is a major community and teaching facility treating the adult patient in an acute and long term care setting.

- We have full-time, part-time and on-call general duty positions available in Medicine, Surgery and Spinal Cord Injury Unit.
- Experienced Critical Care Nurses are required for our Surgical and Medical Intensive Care Units and the Critical Care Nursing Pool.

**Why Not Make Your Move Before That Long, Cold Winter Sets In!!**

## Administrative Supervisor

An opening is available for a Registered Nurse who has the initiative to seek advancement in his/her career.

This position offers a challenge:--the opportunity to be responsible for all activities pertaining to patient care delivery during the night shift.

A good clinical background in critical care nursing and effective leadership skills is essential.

Preference will be given to applicants with recent administrative experience and/or BSN.

Applicants must be eligible for registration in British Columbia. **Salary:** \$2,030.00 - 2,230.00 per month.

Phone or write, detailing your qualifications and experience to:

Jane M. Mann  
Nursing Recruiter  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C. V6H 3N1  
(604) 876-6767, local 431

**SHAUGHNESSY HOSPITAL**  
4500 Oak Street  
Vancouver, B.C. V6H 3N1

**OPPORTUNITY**

**Alberta**

## Team Leaders - Edmonton

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2

- CNA convention highlights
- Malignant hyperthermia: the facts
- Living with dying
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The chain of office passes out of the hands of retiring CNA president Helen Taylor and into those of incoming president Shirley Stinson. Our coverage begins on page 18. Cover and inside photos by B.C. Jennings, Vancouver.

# The Canadian Nurse

September 1980 Volume 76, Number 8

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The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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# perspective

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## A PRACTICAL GOAL FOR THE 80's

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Nursing research. Is it relevant? Is it necessary? Strange questions to ask in 1980 when the answer is so obviously yes? Does it follow that research is a part of all nursing practice? If so, must all nurses be research-minded?

In seeking answers to these questions we find ourselves posing further queries relating to research and nursing service.

- Can nurses provide effective and logical nursing interventions for the patients they are preparing for surgery without knowledge of nursing research on presurgery fasting?
- Can nurses provide relevant care for the dying person and his family if they are not aware of nursing research findings that help them to understand their feelings and those of their patient?
- Can they provide optimum nursing care for the patient in pain if they are not aware of research on pain control?
- Can they develop their independent role as nurses if they do not know the research findings on wellness? Are they sensitive to the latest findings about the strengths and limitations of tools such as health indicators?

We believe the answer to these questions is NO; we believe that nurses cannot practice effectively unless they have some awareness of such research findings, however limited such findings may be at this point in time. To know about our gaps in knowledge we must know our achievements.

It would be unrealistic to expect all nurses to become involved in conducting research. Nevertheless, all nurses do need to know the results of research and how to apply these findings to their specific area of nursing. Until every nurse asks the question, "What research has been done to help me with this nursing care problem (or nursing education problem or nursing administration problem)?", we will continue to fly by the seat of our pants in providing nursing care and fail to build a body of knowledge specific to nursing.

The progress of nursing research has been slow: almost nothing until the 1900's (although Miss Nightingale gave us a beginning) and even since the 1900's much of the research on nursing has been done by non-nurses. Nursing researchers, that is, researchers educated as nurses, have really only been

available in the last 20 years. It is only in the last *ten* years that the term *research* has become a legitimate part of the vocabulary in an undergraduate nursing curriculum.

Could this scarcity of nursing research in Canada and an increasing awareness of the need for it be one of the reasons for the enthusiastic response to the six national conferences on nursing research that have taken place during the past nine years? The 300 Canadian nurses who attended the first national conference in 1971 blazed a trail for those to follow. This first conference was made possible by Department of National Health and Welfare funds awarded to the University of British Columbia School of Nursing. It was organized by members of that faculty but held in Ottawa. The focus was on a review of nursing research and on generating interest. That this was a milestone in the development of research in Canadian nursing, is evidenced by the five conferences that followed. The national sharing of funding and hosting of these conferences by provincial education and service groups is further evidence of a growing nursing research consciousness.

National conferences in nursing research are now part of the pattern; nurses need to meet to identify research areas, to find solutions to common problems and to further develop their research skills. Taken together, these conferences contribute to a broader base of research-mindedness in the community. The seventh national conference, which takes place this year in Halifax from October 22 to 24, moves us close to a decade of sharing nursing research on a national basis. The topic is fitting: a research basis for nursing in the 80's.

Yes, nursing research is relevant and necessary. Nursing cannot achieve full professional status without it. How can nursing care be improved unless it is through the demands of all nurses for more and better research into all aspects of nursing?

**Marion Allen**  
assistant professor, and

**Myrna Slater**  
associate professor,  
School of Nursing,  
Dalhousie University.



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# UPDATE ON DYSMENORRHEA

## Shortcomings of traditional therapies

Surveys show that up to half of female patients may live a sixth of their reproductive years in pain. Yet many of these women are reluctant or embarrassed to talk about their problem, preferring to self treat with analgesics, or simply accepting their condition.

The Lancet, as recently as 1978, reported: "Current treatment of primary spasmodic dysmenorrhea is unsatisfactory. Powerful analgesics may be habit forming, dilatation of the cervix may cause incompetence, and the use of oral contraceptives seems unjustified unless contraception is required."<sup>2</sup>

## How prostaglandins fit into the clinical picture

In the 1940's it was theorized that a 'menstrual toxin' existed which was involved in causing the pain and other related problems. Recent investigations have indicated that increased premenstrual endometrial prostaglandin levels (particularly levels of prostaglandins  $E_2$  and  $F_2$  alpha) may play an important role in the etiology of dysmenorrhea.

## How Ponstan assists in relieving dysmenorrhea

Most non-steroidal anti-inflammatory agents are inhibitors of prostaglandin synthesis—the enzyme system responsible for the formation of prostaglandin.

The fenamate group of anti-inflammatory drugs have a twofold action: they inhibit the enzymes of the prostaglandin synthesis pathway and also antagonize prostaglandins at the receptor sites.<sup>1</sup>

## Ponstan versus conventional analgesics

Recent clinical trials have demonstrated that Ponstan is, indeed, a useful drug in the treatment of dysmenorrhea, affording relief in some 89.3% of patients cycles.<sup>3</sup>

In a double-blind comparison of dextropropoxyphene/paracetamol capsules (2 caps of 32.5 mg/325 mg t.i.d.) and Ponstan (2 caps of 250 mg t.i.d.), Ponstan was significantly more effective than the analgesic combination on both clinically determined and subjective patient preference assessments. There was also less absenteeism in the group taking Ponstan.<sup>4</sup>

## Alternative therapy to oral contraceptives

Ponstan provides prompt relief of dysmenorrhea, and may thus be considered a more rational therapy than oral contraceptives.

In a recent survey, 55% of women taking oral contraceptives stated that these agents had not solved their dysmenorrhea problems.<sup>5</sup> Ponstan has demonstrated a much higher success rate without disturbing the normal hormone balance of patients. Unlike oral contraceptives, Ponstan is taken only when required, i.e. when menstrual pain becomes evident. For the rest of the month the patient may be free of medication.

## Ponstan: a simple short-term regimen

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**INDICATIONS:** For the relief of pain in acute or chronic conditions such as dysmenorrhea, headaches and muscular aches and pains, ordinarily not requiring the use of narcotics.

**DOSE:** Administration is by the oral route, preferably with food. The recommended regimen for adults and children over 14 years of age is 500 mg as an initial dose followed by 250 mg every 6 hours as needed. PONSTAN should not be given to children under 14 years of age.

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**PRECAUTIONS:** PONSTAN should be administered with caution to patients with abnormal renal function and inflammatory conditions of the gastrointestinal tract. Caution should be exercised in administering PONSTAN to patients on anticoagulant therapy since it may prolong prothrombin times. PONSTAN should be used with caution in known asthmatics. If rash occurs, the drug should be promptly discontinued.

Mefenamic acid may prolong acetylsalicylic acid induced gastrointestinal bleeding. However, mefenamic acid itself appears to be less liable than

acetylsalicylic acid to cause gastrointestinal bleeding.

**ADVERSE REACTIONS:** In controlled clinical investigation studies of PONSTAN at analgesic doses, up to 1500 mg per day, associated side effects were relatively mild and infrequent. Complaints are dose-related, being more frequent with higher doses.

In 2,594 subjects given mefenamic acid over a period of from 1 to 238 days, the most frequently reported adverse effects were drowsiness (68 subjects), nervousness (28), nausea (20), dizziness (36), gastrointestinal discomfort (10), diarrhea (11), vomiting (5), and headache (2). There were single reports of insomnia, urticaria and dyspnea and facial edema, and 2 instances each of blurred vision, gas and perspiration. There have been a few reports of hematopoietic side effects. A direct cause and effect relationship has not been established.

**SUPPLY:** Each ivory capsule with aqua blue cap contains 250 mg mefenamic acid. Bottles of 100 and 500 capsules.

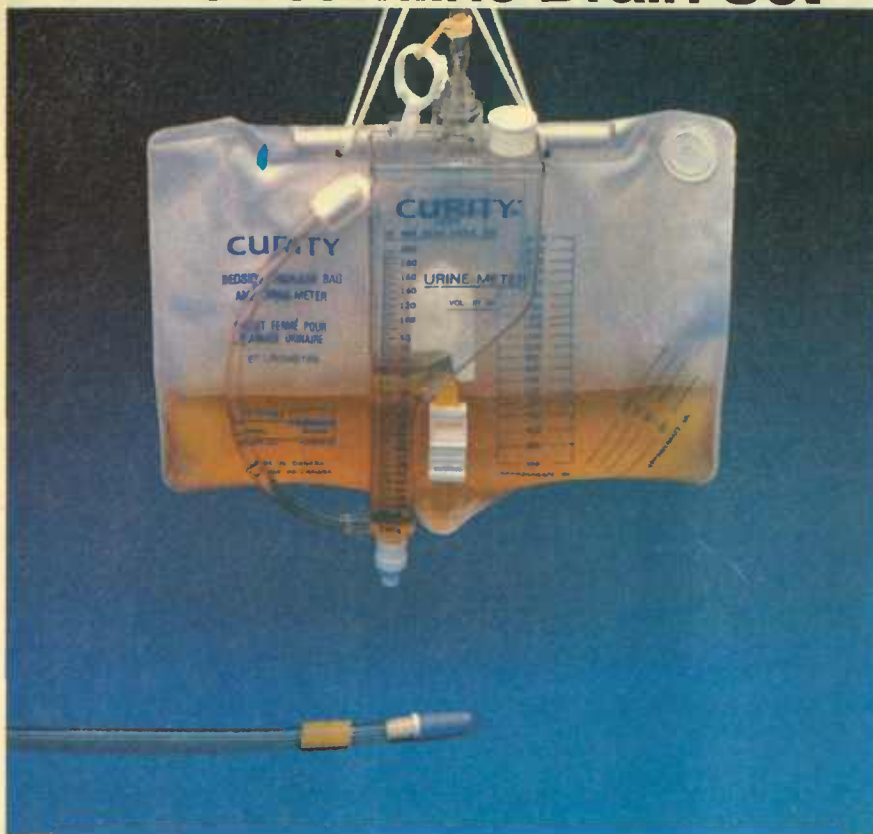
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# input

## The code interpreted

*In response to the issues raised and comments by members at the recent biennial meeting in Vancouver, I would like to remind nurses that:*

From the initiation of the project it seemed clear that whatever model was to be developed for a code of ethics for nurses in Canada, such a model could not address itself to specific issues: the complexity of ethical issues faced by nurses in the 80's does not lend itself to a simple black and white categorization.

As project director, on the basis of the problems submitted by nurses across the country, I came up with more general categories of ethical obligation, all grounded in nursing's mandate to respond to health needs of people and to provide appropriate helping services. The code articulated this mandate by expressing the ethical responsibilities of nursing through the fundamental and unifying characteristic of nursing — caring.

The code is structured around guidelines, including 20 statements of ethical responsibility, preceded by a commentary. It is not a list of do's and don't's but a statement designed to provide a basis for reflection and study. The fundamental responsibility of the nurse to care, to respond to health needs with trust and respect, contain the ethical principles needed to guide nursing action.

It is important that any statement in the code be interpreted in the context of the whole, for example, the following statements provoked a reaction of concern from members who perceived them to be in conflict with union commitments:

*Thus, when a nurse is working under conditions which violate justice, the withdrawal of needed services to patients as a means of resolving such injustice, is unethical.*

*From an ethical point of view, neither the profession as a whole, nor the individual nurse, may resort to strategies that would compromise the health of clients.*

The commentary does not mention collective bargaining, nor does it refer to strike action by nurses. It does, however, emphasize the profession's responsibility to promote conditions which enable nurses to carry out their caring functions.

This could mean that the profession supports legitimate collective bargaining activities of nurses as a way of ensuring appropriate working conditions. The code commentary acknowledges the reality of injustice in working conditions of nurses, but also indicates that there are ethical constraints on the nature and extent of actions taken to resolve such injustice.



Where strike action by nurses is contemplated, important distinctions need to be made. There is a difference, for example, between *total strike* where patients may be held "hostage" to an economic dispute, and *strike action* which takes into account levels of care requirements and provides for care needs which are of an essential nature. Or, in a situation where staffing conditions are poor and resources inadequate for safe care, nurses would be compromising the health of clients by staying in the situation.

Ethical issues are complex. A code of ethics will not make our problems less complex or less ambiguous. The purpose of a code is to sensitize us to the ethical components of the issues we face on a daily basis, and to assist us in responsible discernment based on facts, principles and personal integrity. A code of ethics is not a guarantee against mistakes: hopefully, it will enable us to make fewer mistakes and ultimately to avoid tragic ones.

—Sister M. Simone Roach, St. Francis Xavier University, Antigonish, N.S.

#### Holes in our caring

By chance I read "HELP" by Nelda Yantzie (June). I thought it was an excellent game plan, but there was one glaring oversight.

Along with the 14 living patients, there were six who had symptoms that could be described as psychiatric — one described as hysterical, one "talking loudly and swearing", one "walking as if in a daze", and one "in mild shock".

Two other patients were described as confused. This means that approximately 40 per cent of the patients exhibited some emotional distress. Yet, nowhere in the plan after triage was arrangement made for any sort of psychiatric or psychological support.

I realize that this plan is for a small hospital where only one doctor is available, but I do think it is important that some area in the hospital should be made available for a person with some expertise in helping emotionally disturbed people, such as a nurse or a social worker, to be available to help these patients deal with their emotional reactions.

—J.B. O'Regan, MD, FRCP (C), Associate Professor of Psychiatry, University of Saskatchewan, Chief of Psychiatry, Saskatoon City Hospital.

#### Northern training

The "Bridging the Gap" perspective regarding transcultural nursing (June 1980) was excellent. But what's the next step?

We need a native northern nursing program. The Brandon University Hospital Program is too long and is southern-based. Dalhousie's is post-RN.

Models in western United States are proof that quality training for work in isolation is possible.

—Lionel Orlikon, Winnipeg, Manitoba.

#### ER nurses unite

There has been some preliminary discussion among emergency nursing representatives from Ontario, British Columbia and Alberta about the need for emergency nurses in Canada to have national affiliation.

There will be another meeting at the Ontario Assembly of Emergency Care, October 5-8, 1980, at the Skyline Hotel, Toronto. We hope to hear then from other emergency nurses from the remaining provinces who would be interested in developing a national association.

Interested persons may write to the following address: ENAO, Box 100-217, 2 Bloor St. W., Toronto, Ontario, M4W 3E2. As far as we know, Ontario, British Columbia and Nova Scotia have formalized provincial membership;

Alberta has a less formalized structure but very similar objectives. Provincial membership is not a pre-requisite for demonstrating interest in national affiliation.

—Pat McGuire, president, Emergency Nurses Group of British Columbia.

—Sandra Easton, president, Emergency Nurses Association of Ontario.

#### Overseas mail

I write to acknowledge receipt of your journals. I really appreciate your faithfulness and would say I have been finding it very useful.

The April issue with the articles on exercises and the test project draft have been very useful to me.

Hoping to read more.

—A.A. E. Olaogun, University of Ibadan, Ibadan - Nigeria. (Continued on page 54)

## "When I was thirteen, I really wanted to be a nurse. Today I remembered why."



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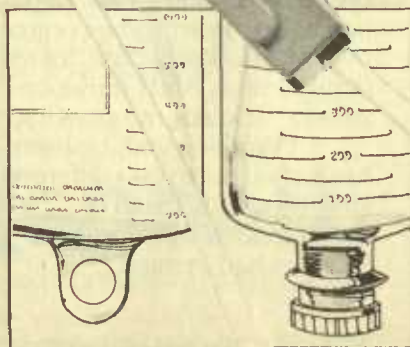
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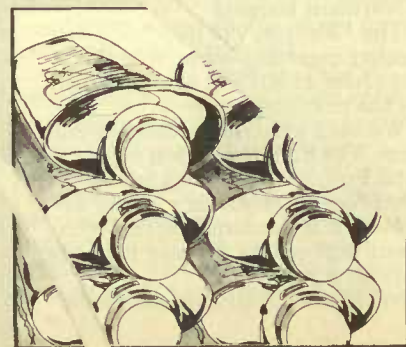
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The rigid neck and wide opening  
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are easy to read, during filling and



Fill, cap, and stack in the refrigerator.



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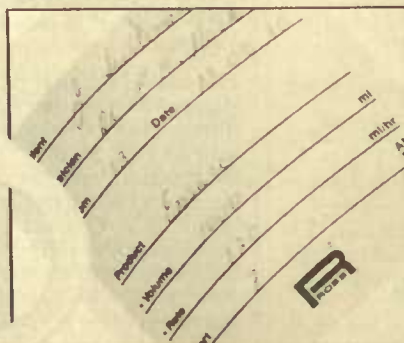
Like a bag, it is light, shatterproof, and disposable.

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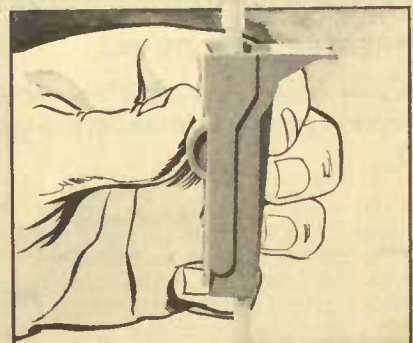
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The CAIR\* clamp allows fingertip control of flow rate.





# calendar

## September

The Psychiatric Nurses Association of Canada will hold its 1980 annual meeting Sept. 22-26 at the Devonshire Hotel, Vancouver. Contact: *Psychiatric Nurses Association of Canada, 871 Notre Dame Ave., Winnipeg, Manitoba R3E 0M4.*

## October

The Association of British Columbia Enterostomal Therapists will hold their annual teaching seminar for health professionals Oct. 2-3 at the Public Health Centre, Nanaimo, B.C. Contact: *Aileen E. Barer, Enterostomal Therapy Center, Royal Jubilee Hospital, 1900 Fort St., Victoria, B.C. V8R 1J8.*

A two-day workshop on pain will be held at the University of Manitoba Oct. 9-10, featuring author Margo McCaffery. Contact: *Prof. Erna Schilder, School of Nursing, University of Manitoba, Winnipeg, Man. R3T 2N2.*

The first annual meeting and workshop of the Canadian Association of Quality Care Coordinators will be held in North Bay, Ont., Oct. 2-3. Contact: *Brian Rogers, St. Joseph's General Hospital, 720 McLaren Ave., North Bay, Ontario.*

"The Nurse as a Community Activist—Leadership and Personal Influence" is the theme of the annual workshop of the Community Mental Health Nurses Association of Ontario to be held Oct. 3 at the Ramada Inn Airport West, Mississauga, Ont. Contact: *Lynda Hessey, York Community Services, 1651 Keele St., Toronto, Ontario M6M 3W2.*

"Continuing Professional Education: Moving into the 80's" will be presented by the University of Calgary, October 22-24. Contact: *The Faculty of Continuing Education, The University of Calgary, Calgary, Alberta, T2N 1N4.*

A national conference on Smoking Prevention for the Young, sponsored by the Manitoba Interagency Council on Smoking and Health will be held in Winnipeg, Oct. 17-19. Contact: *Manitoba Heart Foundation, 301-352 Donald St., Winnipeg, Man. R3B 2H8.*

Queen's University School of Nursing Alumnae of all years are invited to a special dinner in conjunction with the Queen's Reunion Weekend, Oct. 17-19. Contact: *R. Maloney, Queen's University, School of Nursing, Summerhill, Kingston, Ontario K7L 3N6.*

The Canadian Association on Gerontology will hold its annual scientific and educational meeting, October 16-19 at the Hotel Bessborough, Saskatoon, Sask. Contact: *Dr. Duncan Robertson, Program Chairman CAG '80, Box 7997, Saskatoon, Sask. S7K 4R6.*

The Ontario Occupational Health Nurses 9th annual conference will be held at the Holiday Inn, Ottawa, October 20-24. Contact: *Mrs. S. Smith, Registration, Room 600, Bell Canada, P.O. Box 8239, Ottawa, Ont. K1G 3J4.*

The Greater Vancouver Mental Health Service presents "The Community Approach—Mental Health or Mental Illness?" on Oct. 30-31. Contact: *G. V. M.H.S. Conference Committee, 201-828 West 8th Ave., Vancouver, B.C. V5Z 1E2.*

The Amsco Seminar on Sterilization in O.R. and C.S.R. will be held Oct. 27-29 at the Place Dupuis Holiday Inn, Montreal. Contact: *Victoire Audet, 1275 Cote Vertu, Ville St. Laurent, Quebec, H4L 4V2.*

The annual seminar of the Manitoba Operating Room Nurses Study Group will be held on Oct. 30 in conjunction with the Manitoba Health Organization Conference. Contact: *Judy Cameron, Operating Room, Health Sciences Centre-General, 700 William Ave., Winnipeg, Man. R3E 0Z3.*

The fourth annual Nursing Lecture Series co-sponsored by the University of Manitoba School of Nursing and the Victorian Order of Nurses, Winnipeg Branch featuring Dr. Jacqueline Chapman, will be held Oct. 9. Contact: *June Bradley, Acting Director, School of Nursing, The University of Manitoba, Winnipeg, Man. R3T 2N2.*

The York-Toronto Respiratory Care Society annual respiratory update will be held Oct. 23 at the Royal York Hotel. Contact: *York-Toronto Lung Association, 157 Willowdale Avenue, Willowdale, Ontario, M2N 4Y7.*

## November

Depression in the 80's: the most common mental disorder is a two-day symposium being held Nov. 3-4 at the Sheraton Caswell Inn, 1696 Regent Street South, Sudbury, Ontario. Contact: *Alice Shaw, Staff Development Department, Sudbury Algoma Sanatorium, 680 Kirkwood Dr., Sudbury, Ontario P3E 1X3.*

An Update on Peritoneal Dialysis is the subject of a workshop to be presented by the Toronto Western Hospital for nurses and other paramedical personnel, Nov. 8. Contact: *Sharron Izatt, Program Coordinator, c/o Peritoneal Dialysis Unit, Toronto Western Hospital, 399 Bathurst St., Toronto, Ontario, M5T 2S8.*

The Canadian Intravenous Nurses Association will hold its 5th annual convention at the Inn on the Park, Toronto, Nov. 13-14. Contact: *C.I.N.A. 4433 Sheppard Ave. E., Suite 200, Agincourt, Ontario, M1S 1V3.*

"Ethical Issues In Psychiatric Nursing", a workshop designed for RPN's and RN's employed in psychiatric settings, will be held Nov. 14-15. Contact: *Roy Morris, Health Continuing Education, B.C.I.T., 3700 Willingdon Ave., Burnaby, B.C. V5G 3H2.*

Contributions to CALENDAR are published free of charge as space permits. For more than one insertion or to ensure publication in a specific issue, please consult our advertising department. ☛

## Students & Graduates



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# news

## Nurse heads CPHA

For the second time in the 71-year history of the Canadian Public Health Association, a nurse has been elected president. Marie des Anges Loyer, director of nursing and associate dean of health sciences at the University of Ottawa, assumed office during the annual CPHA conference in June 1980.

Loyer told *The Canadian Nurse* that, as president, she hopes to work closely with provincial nursing and public health associations to put pressure on their respective governments for increased financial support. "This is a significant mandate for nurses in public health," she said.

Ten years ago, Geneva Lewis, then director of public health nursing for the Ottawa-Carleton region, was elected president.

Three other nurses were also named to the CPHA board of directors: Jill Christensen from the Northwest Territories branch, Karen Mills from the Alberta Public Health Association and Ann Harling from the New Brunswick/Prince Edward Island branch.

The conference, held in Ottawa, was attended by more than 650 delegates and centered on the theme "public health in the 80's—opportunity or demise".

Maureen Law, MD, assistant deputy minister of the national department of Health and Welfare and keynote speaker, was optimistic about the future. "I most certainly see the 80's as a decade of great opportunity for public health," she said.

Dr. Law foresaw prevention programs, health promotion and public health manpower as instrumental to the achievement of the federal goal of "health for all by the year 2000". She told members this goal could only be attained through their "concentrated effort" and that public health practitioners should not "go on to administrative or academic careers" because of the shortage of manpower.

Ottawa Mayor Marion Dewar, who is also a nurse, challenged delegates to a more specific public health opportunity: that of aiding in the resettlement of Vietnamese refugees.

CPHA's 1981 conference will be held in Saskatoon next June.

## Nurse administrators hold first national conference

"Lab-coated, harried and absolutely demystified, coping in ways most suited to her personal style, comfort and sanity level," that's how nurse administrator Roberta Coutts of Ottawa sees her fellow DON's. "The nurse administrator of today has a calculator on her desk, a ministry report in her drawer and a grievance in her IN basket," Coutts told close to 200 registrants attending the first national Nurse Administrators Conference in Vancouver last June 25 and 26.

Coutts, director of nursing of the Ottawa General Health Sciences Centre, who delivered the keynote address, "Functional aspects of administering nursing in the '80's", suggested that what nurse administrators need are not more courses in caring but, instead, "the wiles and guiles of a hungry cheetah!"

"Why has the question arisen of whether or not a director of nursing must be a nurse," Coutts wondered. "Is it because there are nurse administrators who cannot effectively run interference for nursing, or choose not to? Is it because they themselves are intimidated or have accepted the power and status dictated by others?"

The conference, which was sponsored by the Canadian College of Health Service Executives in cooperation with the Canadian Nurses Association and the Nursing Administrators Association of British Columbia, featured an impressive list of speakers.

Proceedings of the meeting will be compiled and available from the Canadian College of Health Service Executives, British Columbia

Education Services, 440 Cambie St., Vancouver, B.C. V6B 2N5, at a cost of \$10.50 (including mailing charges).

## Continuing ed challenge topic for national meet

What nurses in this country need, according to an expert on the American scene, is a statement by their professional organization on the meaning of continuing education for the nurse *as a professional* and for the nurse *as a worker*, with a distinction made between the two.

Dr. Dorothy del Bueno who is associate dean in the Continuing Education Faculty at University of Pennsylvania and consultant in inservice education at the Hospital of the University of Pennsylvania, made the comment in her keynote address to nurses attending the second national Continuing Education Conference in Vancouver June 26 and 27.

"There is some overlap," del Bueno noted, "between the nurse as a professional and the nurse as a worker, but there is also a big difference and it is this difference which determines who provides the continuing education and who pays. If the CNA made such a statement, I could almost guarantee that the amount of continuing education available to Canadian nurses would increase."

Addressing the need for strategies for cost effective educational programs, del Bueno presented her own formula for determining the cost effectiveness of individual programs. By considering the learner from three perspectives, as a person, as a professional and as a worker, it is easier to examine the issue.

"The criterion for determining who does what, must be an economic criterion, based on return on investment," she said. "The group that will receive the greatest return for the investment should pay for it." She also reminded her audience that the greatest cost involved in continuing education is that of the time of the learner; it is very effective if the agency can contract the program out so that the individual will take the course on her own time.

More than 125 nurses from across the country attended this second national conference with the theme of "Continuing Nursing Education: Planning for the 80's." The first such conference took place in Winnipeg in April, 1979. Copies of the proceedings of the first conference are still available at a cost of \$8.40 (includes postage) and may be obtained by writing to Dr. Helen Niskala, 310-6055 Vine St., Vancouver, B.C. V6M 4A3. Proceedings of the 1980 meeting are to be published at a later date. ♡

## ICN SETS CONGRESS FEES

Registration fees for ICN's 17th Quadrennial Congress in Los Angeles June 28-July 3, 1981 have been set by ICN directors. The fee schedule is as follows:

Registration	Nurses	Students
Early (until February 28, 1981)	US\$ 90.00	US\$ 45.00
Late (until April 30, 1981)	110.00	55.00
Advance (per day)	30.00	15.00

Registration takes place through ICN's 89 member associations. Any nurse belonging to an ICN member association (such as CNA) is eligible to attend the congress.

A preliminary program is now available from CNA; included in this program are registration and hotel accommodation forms.







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**CNA moves into the eighties,  
politically active, professionally challenged**



## Opening ceremonies

"I declare this 1980 meeting of the Canadian Nurses Association officially open." President Helen Taylor's words touched off an enthusiastic round of welcoming speeches, telegrams of congratulations and greetings from representatives of various health-related disciplines.

British Columbia's new (seven months) Minister of Health, Rafe Mair, congratulated RN's "individually and collectively" on the representations made to his government by nurses in his province and on the proposals for alternate forms of health care set out in CNA's brief to the Hall Commission. "The question of salaries for all health care personnel will almost certainly become a matter of debate in BC," he predicted.

Canadian Verna Splane, second vice-president of the International Council of Nurses, brought greetings from the ICN of which Canada has been a member for 70 years.

American Nurses Association president Barbara Nichols expressed her happiness at being able to represent the 185,000-member sister association of CNA and reminded Canadian nurses of their shared roots in the Nurses Associated Alumnae of the United States and Canada, forerunner of CNA.

The president of the BC nurses association, Stephany Grasset, welcomed the more than 1000 nurses attending the convention to "Vancouver, Renaissance City, and a fitting site for the renaissance of nursing".

## Kellogg Lecture

"Primary care: nursing" was the topic chosen by Kellogg Lecturer Dr. Lea Zwanger for her presentation on current and emerging problems in health care. To illustrate her points Dr. Zwanger used the example of primary care units "pivoted by a nurse" serving a kibbutz in Israel.

"The health services of a kibbutz," Dr. Zwanger pointed out, "have all the essential attributes that characterize primary care, ie. accessibility, comprehensiveness, coordination, continuity and accountability."

Although practical problems a kibbutz nurse faces are not necessarily different from those encountered by nurses in other primary care units, Dr. Zwanger said, the dual role of member of the kibbutz and nurse imposes an emotional burden on these primary care providers. "She must resolve these ethical and practical dilemmas alone."





CNA president Helen Taylor (left) with B.C. Minister of Health, Rafe Mair and Stephany Grasset, RNABC president, welcomed CNA members and visitors to the 1980 meeting.

Wallis/Tregillas Photography, Vancouver

Dr. Zwanger touched briefly on the nursing education situation in her home country, describing current efforts to put more emphasis on "neglected population care". She said that to date "we have failed to fit our graduates with nursing abilities to care for future patients' needs or demands. We know that a larger number of elderly with multiple pathology and greater dependence on nursing will need our graduates. We know that complexities of life will result in increasing anxiety conditions and psychiatric illnesses. But, so far, a drastic adaptation of nursing education programs has not occurred."

"In our changing world we are exposed to problems and challenges unforeseen by our ancestors. We must therefore develop, within ourselves, the ability to adapt to scientific advances, to changing trends in health care and to a changing social order."



Dr. Lea Zwanger



Lorine Besel

#### Keynote address

"It is time to go back to our roots, to enact, adhere to and derive our sense of direction for practice, teaching and research from *caring*," keynote speaker Lorine Besel told a packed audience on the opening morning of the convention. Besel, who is director of nursing at the Royal Victoria Hospital in Montreal and a former member of the CNA Board of Directors, explored the question of "who will shape nursing in the eighties?"

Her advice to nurses: "Forget the 'mini-doctor kick'. Let's establish our own power base and bring forward our own special contribution to patient/client care."

"Decision-making that counts," according to Besel, "depends on fostering the growth of an informed and educated leadership power base that will:

- compete as peers on the interdisciplinary health team
- analyze health care delivery problems and prepare recommendations for change with objective supporting data and
- research the health care needs of the communities and individuals we serve."

Besel called on nurses to make more use of their professional associations in their efforts to obtain monetary recognition of nursing's real contribution to the health care situation. "Professional nurses *should* be paid more," she said. "In my view we ought to be the highest salaried of all health professionals — including doctors. The rest are the true 'ancillary' services."

In the eighties, Besel warned, the impact of current fiscal constraints could result in violence becoming an area of major health concern. "Wherever and whenever you underpay, underrate, undersupport, undervalue the persons who are designated to care, you create a situation where some humans may abuse other humans." Battering professional "care-takers" in the hospital setting could, in time, become as common as the battering "care-takers" we already know about in the community...mothers who take care of children, even children who take care of aged parents.



Robyn Tamblyn



### Monday luncheon speaker

Adaptation of the nurse practitioner role to allow the nurse to live up to her potential was the theme of 'mystery luncheon speaker', Robyn Tamblyn. Speaking from the vantage point of her experience in the areas of nursing research, education and practice, Tamblyn addressed the problem of specialization within the profession. "Cost and confusion" are included in the toll exacted from the patient who is subjected to increasing layers of specialization, she declared.

Tamblyn, whose specialty is neurological and neurosurgical nursing, has worked as neurological nurse in team practice at McMaster University, Hamilton, Ontario, where she is currently a clinical lecturer.

It has been shown that the less clearly nurses perceive nursing practice, the more difficult it is for them to join or participate in a professional association and also the more negative perceptions nurses hold of their colleagues, the less they will want to take part in their professional association. If professional associations accept these difficulties, Professor Foucher suggests they must reassess what they have to offer their membership. To encourage nurses to join the association or to consolidate compulsory membership, members must feel that they have some influence on the direction of the association, they themselves must be allowed to develop, the association must provide advantages that nurses currently value and the



*Ginette Rodger chaired panel on labor relations and professional associations.*

### Labor movement vis-a-vis the professional association

"Is dual allegiance to nursing union and professional nursing association still possible?" was the question Professor Roland Foucher, labor analyst and industrial psychologist, posed in his address to CNA convention delegates. "During the last decade we have been witness to the separation of professional associations and unions of nurses across Canada for several reasons, many of which are legal in nature and dependent upon changes in values." Professor Foucher feels that nursing unions are somewhat unique due to their strongly female membership, the values held typically by women and the values typically attributed to women and as well by the initial reluctance and frequent refusal of nurses to use the strike approach (in a recent study of Quebec nurses, 70 per cent of the respondents considered devotion to duty an essential feature of nursing). Similarly professional nursing associations differ from the norm as human relationships are more highly valued by members than success or rewards.

professional association must be viewed by its members as having some power to improve the profession.

Aline Michaud, présidente, Fédération des syndicats professionnels d'infirmières et d'infirmiers du Québec:

*"Can we say that the nursing union movement is healthy? I believe that currently our nursing unions are choosing the road towards health, both for themselves and for society. In the future, the influence of the unionization of nurses on the profession of nursing will be dependent upon the orientation and ideologies which develop."*

Louise Lemieux-Charles, project coordinator, College of Nurses of Ontario:

*"Conflict is certain to arise when more than one organization not only represents the member's interests, but is also required to ensure the public's interests. A co-operative role must therefore characterize our relationships and we must not only identify through discussion our areas of conflict but also decide how we want to deal with them."*



### The Great Debate Continuing education: mandatory vs. voluntary

Kathie Clark, education coordinator, Registered Nurses Association of Ontario, Toronto:

*"Maintenance of competence is a complex problem requiring a complex solution. Mandatory continuing education is a simplistic approach. Use of this theory will drain our education systems of vital resources to be used for approval mechanisms and cumbersome recording, a false sense of security will be created among nurses and will actually sidetrack the real issue of competence."*

Norma Fulton, associate professor and director, Continuing Nursing Education, College of Nursing, University of Saskatchewan:

*"We cannot leave it to individuals to choose whether they will involve themselves in continuing education. What about the nurse who doesn't perceive a need? How can we be sure that the individual nurse will select an appropriate educational resource? Mandatory continuing education allows for accountability, the very essence of professionalism."*

Rita Lussier, conseiller en formation professionnelle, Ordre des infirmières et infirmiers du Québec, Montréal:

*"The learning experience occurs within an individual independent of outside forces. Motivation requires one's own consciousness and determination. Mandatory continuing education ignores the main components of freedom of choice and liberty."*

Margaret Steed, professor and associate dean, Faculty of Nursing, University of Alberta, Edmonton:

*"The real issue and thrust of nursing practice is based on continuing education, the assurance of competency. With galloping technology, specialized aspects of practice and care delivery, mandatory continuing education has been shown to be the only effective method of ensuring safety to practice. This shouldn't be called 'the Great Debate', it should be known as 'the Dumb Argument'."*





### The health care system and Canadian public policy

"We are currently experiencing and witnessing the deterioration of what we thought was one of the best health care systems in the world," Dr. Malcolm Taylor, professor of public policy, Faculty of Administrative Services, York University, Toronto, told delegates to CNA's annual meeting. In his presentation "The health care system and Canadian public policy", Dr. Taylor noted that "what is happening in the health care system seems also to be happening in the education and welfare systems, all of

that our explained sible realities turn are an ntal ently, as our policies. are out of d and policy cause of the ovinces, ups, more Taylor am shoulders eating new with their their goals. urses will eady ing others.

### Reaction panel

Judy Fraser, occupational health nurse, Winnipeg, Manitoba:

*"I feel that there remains one major flaw in the health care system, as the largest portion of health care dollars are still being spent on the treatment of the ill and injured, neglecting the area of prevention, with the most neglected area for the maintenance and promotion of health being in the workplace."*



Jessica Ryan, head nurse, pediatric service, Chaleur General Hospital, Bathurst, N.B.:

*"There are too many people in the institutions we call hospitals; there are too few personalized regional and community health care centers in our nation and far too many depersonalized and dehumanized buildings."*

*"I believe that too many children enter hospital; too many children stay in hospital too long and are thus traumatized by this experience, and too many children are admitted over and over again for conditions which could and should be cared for by mothers at home."*

*"People have to be taught, starting in kindergarten, how to look after their bodies. If everybody in Canada washed their hands nine or ten times a day, had a bath every day and washed their hair once a week I am convinced our health costs would be cut way down."*



Shelley Kremer, general duty nurse, B.C. Cancer Control Clinic, Vancouver, B.C.:

*"I think that the health care system is a little like Christopher Columbus who set out not knowing where he was going, arrived not knowing where he was, returned not knowing where he had been and all on someone else's money."*

*"Although demands by the public and health care workers may seem excessive, are they really? It is really only acute care that is out of bounds. Why didn't our architects of health insurance realize that as the population aged, so would acute care demands increase. This is an epidemiological principle today just as it was in 1958."*



Phyllis Barrett, executive secretary, Association of Registered Nurses of Newfoundland:

*"We know where we want to go. Nurses have declared for change and reform. We have declared with confidence (in our brief to the Hall Commission) that we are capable of putting health into health care. We need change. We need reform and we, the nurses of Canada, can do this."*





Monday luncheon speaker  
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mandatory vs. voluntary

Kathie Clark, education coordinator, Registered Nurses Association of Ontario, Toronto:

*"Maintenance of competence is a complex problem requiring a complex solution. Mandatory continuing education is a simplistic approach. Use of this theory will drain our education systems of vital resources to be used for approval mechanisms and cumbersome recording, a false sense of security will be created among nurses and will actually sidetrack the real issue of competence."*

Norma Fulton, associate professor and director, College of Nursing, University of Saskatchewan:

*"We cannot choose whether we choose ourselves in. What about perceive a ne that the indi appropriate e Mandatory c for accounta professional."*

Rita Lussier, professionne et infirmiers

*"The learning, an individual forces. Motiv consciounes Mandatory c the main con choice and li"*

Margaret Steadman, dean, Faculty of Nursing, University of Alberta, Edmonton:

*"The real issue and thrust of nursing practice is based on continuing education, the assurance of competency. With galloping technology, specialized aspects of practice and care delivery, mandatory continuing education has been shown to be the only effective method of ensuring safety to practice. This shouldn't be called 'the Great Debate', it should be known as 'the Dumb Argument'."*

READERS

CANADIAN NURSE

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### The health care system and Canadian public policy

"We are currently experiencing and witnessing the deterioration of what we thought was one of the best health care systems in the world," Dr. Malcolm Taylor, professor of public policy, Faculty of Administrative Services, York University, Toronto, told delegates to CNA's annual meeting. In his presentation "The health care system and Canadian public policy", Dr. Taylor noted that "what is happening in the health care system seems also to be happening in the education and welfare systems, all of the humanitarian systems that our society has undertaken." He explained that public programs are visible realities of public policies which in turn are an expression of our fundamental underlying values. Consequently, as our values change, so must our policies.

Just now, "the times are out of joint, the mood has changed and policy making is more difficult because of the increasing powers of the provinces, more powerful interest groups, budgetary constraints and more prevalent sexualism." Dr. Taylor suggested that the health team shoulders a major responsibility in creating new policies by inspiring others with their idealism and dedication to their goals. Specifically, he feels that nurses will respond since they have already dedicated their lives to helping others.



### Reaction panel

Judy Fraser, occupational health nurse, Winnipeg, Manitoba:

*"I feel that there remains one major flaw in the health care system, as the largest portion of health care dollars are still being spent on the treatment of the ill and injured, neglecting the area of prevention, with the most neglected area for the maintenance and promotion of health being in the workplace."*



Jessica Ryan, head nurse, pediatric service, Chaleur General Hospital, Bathurst, N.B.:

*"There are too many people in the institutions we call hospitals; there are too few personalized regional and community health care centers in our nation and far too many depersonalized and dehumanized buildings."*

*"I believe that too many children enter hospital; too many children stay in hospital too long and are thus traumatized by this experience, and too many children are admitted over and over again for conditions which could and should be cared for by mothers at home."*

*"People have to be taught, starting in kindergarten, how to look after their bodies. If everybody in Canada washed their hands nine or ten times a day, had a bath every day and washed their hair once a week I am convinced our health costs would be cut way down."*



Shelley Kremer, general duty nurse, B.C. Cancer Control Clinic, Vancouver, B.C.:

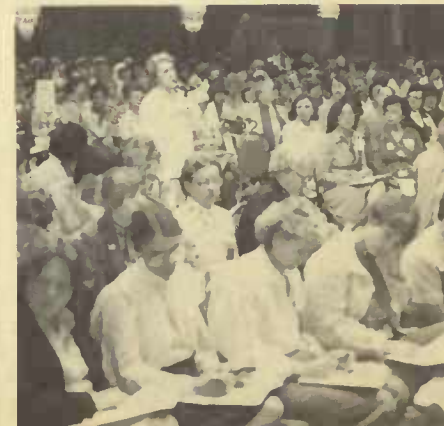
*"I think that the health care system is a little like Christopher Columbus who set out not knowing where he was going, arrived not knowing where he was, returned not knowing where he had been and all on someone else's money."*

*"Although demands by the public and health care workers may seem excessive, are they really? It is really only acute care that is out of bounds. Why didn't our architects of health insurance realize that as the population aged, so would acute care demands increase. This is an epidemiological principle today just as it was in 1958."*



Phyllis Barrett, executive secretary, Association of Registered Nurses of Newfoundland:

*"We know where we want to go. Nurses have declared for change and reform. We have declared with confidence (in our brief to the Hall Commission) that we are capable of putting health into health care. We need change. We need reform and we, the nurses of Canada, can do this."*







*Shirley Stinson*



*Sue Rothwell*



*Mary Murphy*



*Jessica Ryan*



### Meet your new executive!

A new slate of officers is at the helm of your professional association following voting at the 1980 annual convention in Vancouver. In charge is president Shirley M. Stinson, professor in the Faculty of Nursing and Division of Health Services Administration at the University of Alberta, assisted by president elect Helen Glass, coordinator of the Graduate Program in Nursing at the University of Manitoba School of Nursing.

Three familiar faces from the previous biennium are those of second vice president Myrtle E. Crawford, assistant dean, College of Nursing, University of Saskatchewan; member-at-large for nursing research, Odile Larose, director of the Nursing Sector of l'Ordre des infirmières et infirmiers du Québec; and member-at-large for nursing practice, Jessica Ryan, head nurse, Chaleur General Hospital, Bathurst, N.B. All are serving their second term in these offices.

Other officers are: first vice president Sue Rothwell, director of nursing and assistant professor at the Cancer Control Agency of British Columbia; member-at-large for nursing administration, Mary Murphy, vice president, Nursing, Vancouver General Hospital; member-at-large for nursing education, Patricia Stanojevic, staff development officer, George Brown College, Toronto; and member-at-large for social and economic welfare, Winnifred E. Kettleson, employment relations officer, Nova Scotia Nurses Union, Halifax.



*Odile Larose*



*Helen Glass*



*Myrtle Crawford*



*Patricia Stanojevic*



*Winnifred Kettleson*



In a warm and sincere tribute to all of those she worked with — both nurses and non-nurses — during her 17-year career as executive director of Canada's national nursing organization, Helen K. Mussallem acknowledged the help and assistance of:

- all of the staff at CNA House
- her family who taught her "what dedication is all about"
- her teachers and her students who "taught me more than I ever taught them"
- colleagues who directed her attention to overseas assignments and co-workers in other disciplines, including those who "disputed the passage".

She paid tribute, too, to "my many friends from Cape Race to Nootka Sound", the nurses who through their provincial association are members of CNA, and recalled humorous incidents that had occurred in each of these provinces during her visits there.

"There are many problems, many responsibilities still before you," she said, pointing out that "we can no longer enjoy the luxury of delay."

"Decisions are not forever, however. What is forever is intellectual honesty, the courage of your convictions and the results and satisfaction you obtain from your labors."

President Helen Taylor, who presented Dr. Mussallem with CNA's "Nurse of Honor" award, reserved for nurses who have made an outstanding contribution to nursing, reminded the audience of some of the many other awards already bestowed on Helen Mussallem. These include:

- Officer of the Order of Canada
- The Canadian Red Cross Citation
- award for Distinguished Achievement in Research and Scholarship, Columbia University
- Commander, Order of St. John
- Honorary Fellow, Royal College of Nursing (U.K.)
- Queen's Silver Jubilee Medal, 1977
- Medal for Distinguished Service, Teacher's College, Columbia University.

She quoted also from the citation Dr. Mussallem received last year from the Royal College of Nurses that described her as "Canada's most distinguished nurse in her generation." Other notable achievements during this time include: establishment of the CNA library and archives, publication of national nursing statistics, construction of CNA House, appointment of two full-time editors for the CNA journals, and admittance of the Northwest Territories Registered Nurses Association.

# THE END OF AN ERA AT CNA

## Tribute to Helen K. Mussallem



*Helen K. Mussallem is awarded the Medal of Service of the Order of Canada with actor Lorne Greene in October 1969.*



*Dr. Mussallem was the first nurse and the first Canadian to receive a Medal for Distinguished Service from Teacher's College, Columbia University, in New York City. Dr. Mussallem, who received her PhD in education from Columbia U, was presented with the award by university president Lawrence Cremin in May, 1979.*



*With Her Royal Highness, Princess Margaret and Sir Michael Coleman last April at Leeds Castle in Kent, England. "I had the gorgeous Walnut Bedroom with a four poster bed, slept in by many queens," Mussallem reminisces. She was a participant in the United Kingdom Seminar for Fellows of the Royal College of Nursing.*



## CNA directors finish 1978-1980 business, prepare for new biennium

The last meeting of CNA directors elected for the 1978-80 biennium took place in Vancouver immediately preceding opening of the association's annual meeting and convention. Although some agenda items will be carried over for action during the coming biennium, one major 1978-80 project, "A definition of nursing practice and standards for nursing practice", was completed on schedule and accepted by directors as "an official document of national significance to be utilized by the various jurisdictions as they see fit." An implementation and interpretation phase will begin immediately.

Action on several items was postponed or deferred by directors until after election of the new slate of officers for the coming biennium. Among the questions this board will deal with are:

- further study of a proposed multiple-step fee increase
- editing and revision prior to re-issuing the association's official statements on nursing and health-related issues
- a decision on an application for affiliate membership in CNA by the Canadian Association of Practical and Nursing Assistants.

In response to concerns expressed by members, directors voted to re-examine one section of the recently released CNA Code of Ethics — the section containing reference to "the withdrawal of services", dealing with "Caring and the healing community". As a result, a committee consisting of five nurses, headed by former CNA member-at-large for social and economic welfare, Linda Gosselin, was constituted to develop a substitute section. The committee will present its findings to the Spring meeting of the board of directors. Committee members, in addition to the chairman, are: Judith Lougheed, president, Association of Nurses of Prince Edward Island; Stephany Grasset, president, Registered Nurses Association of British Columbia; Mary Ann Lamb, RN, of the University of Alberta and Sunny Arrojo, president, Manitoba Organization of Nursing Associations (MONA).

Directors approved the report of two selection committees, one naming the next executive director of CNA (see page 24), the other naming members of an editorial advisory committee which will, under its terms of reference, "provide a systematic and ongoing review of the association's publications, *The Canadian Nurse* and *L'infirmière canadienne*. Committee members are: Jerry Miller, communications officer, Labor Relations Division, RNABC (British Columbia and Northwest Territories); Beverley Pitfield, RN, Gravelbourg, Sask. (Western Provinces); Kate Fulton, RN, (Ontario); Florita

Vialle-Soubranne, Consultant, professional inspection division, Order of Nurses of Québec (Québec); and George Bergeron, communications officer, NBARN, (Atlantic Region).

Directors also approved a list of convention sites for biennial meetings over the next decade. Places and dates are as follows: St. John's, Nfld., 1982; Québec City, 1984; Regina, 1986; Charlottetown, 1988 and Banff, Alberta, 1990.

Directors also heard a progress report on "Operation Bootstrap", a \$5.2 million, multi-faceted, long term project intended to support and foster the development of doctoral preparation of nursing in Canada (see *The Canadian Nurse*, January, 1979). President-elect Shirley Stinson, in her role of liaison person between the CNA Board of Directors and Operation Bootstrap Steering Committee, reported on progress in the committee's continuing efforts to obtain funding for the project from the W.K. Kellogg Foundation. A final decision is expected shortly.



### Outgoing president

Standards, quality of nursing practice, accreditation of nursing education programs and development of a code of ethics for Canadian nurses were signalled out by retiring president Helen Taylor as the most significant of the priorities under review by CNA during the past biennium.

Taylor, who is director of nursing at the Montreal General Hospital, was addressing delegates at the conclusion of her two-year term of office. "Nurses of tomorrow must be steeped in the visions of the future... prepared for a burgeoning work world of science and technology. We will need to learn how to assess the need for specific services that directly affect health and we will require the necessary skills to influence community and national leaders with the aim of promoting healthy environments."



Taylor noted that quality of care in practice settings should be our greatest concern both today and tomorrow. She reminded nurses in the audience that adoption of standards does not guarantee that high quality care is, in fact, being provided. "The individual nurse must assume the greatest proportion of responsibility in adopting and applying these nursing standards in her daily practice."

The CNA Code of Ethics, Taylor observed, "speaks to the relationship of nurses to both clients and the community. It goes beyond what the law states nurses *must* do to help us identify what we *should* do. It highlights areas of accountability that we choose to accept because of personal integrity."

Standards for nursing education and practice, a program of accreditation for nursing education programs, development of resources and facilities enabling nurses to be prepared at the doctorate level, as well as the code of ethics, and a proposed national plan for continuing education, Taylor said, are all issues with a common purpose. "These are tools to enable us to provide the highest possible quality of nursing to our patients in an already complex and rapidly changing society."



### Incoming president

"More and more, I believe that collective professional excellence is needed in order to effect necessary changes within the health care system, as presently the system is being shaped by forces which themselves are of a collective nature, forces which reach well beyond the grasp of any of us as individuals." Dr. Shirley Stinson, newly elected president of the Canadian Nurses Association in her inaugural address to membership, cited the need for strong, relevant professional organization at the international, national, district and local levels. "I believe CNA can play a vital role at the national level and a vital role in strengthening professional organization at all of the other levels."

Dr. Stinson feels that the questions facing CNA today are essentially the same as they were 72 years ago when CNA was founded. However, the answers have changed radically. Whereas in earlier days, CNA focused on developing a collective nursing identity, evolving standards for nursing education, and acting as a clearing house for ideas, the timing and ways in which CNA speaks for nursing have changed. "CNA now responds more quickly to issues rather than waiting for a general consensus. Where CNA's role was primarily reactive in the past, it is now becoming proactive, putting forth new ideas, being in the vanguard rather than the rear guard," Dr. Stinson says, pointing out the ever increasing need for CNA to be strong and relevant.

"Over the next two years CNA must make many informed choices about some very vital questions. No matter how thorny the questions may be, CNA cannot and should not try to be all things to all people. We should use CNA only for those things that are of common interest to all member associations and that are of true significance to the betterment of the public interest and the development of the profession as a whole."

Dr. Stinson, who is a professor in the Faculty of Nursing and Division of Health Services Administration at the University of Alberta, was president-elect of CNA during the last biennium and, before that, first vice-president (1976-78) and member-at-large for nursing education (1974-76). She is a graduate of the University of Alberta (BScN), University of Minnesota (MNA) and Columbia University (EdD). She was project director for the Kellogg National Seminar on Doctoral Preparation for Canadian Nurses (1978) and since then has directed plans for Operation Bootstrap, a program intended to support and foster doctoral preparation for nurses in Canada.



Penny Stiver and Alice Girard, both founding members of CNF, attended the annual meeting. Behind them is the Virginia Star quilt raffled by CNF.



A year-long search for the next chief officer of this country's national nursing organization ended in June when CNA directors approved the appointment of Ginette Rodger to the position of executive director. Rodger, who has been director of nursing at Notre Dame Hospital in Montreal for the past seven years, served as member-at-large for nursing administration on the 1978-80 CNA board of directors. She has a baccalaureate degree in nursing from the University of Ottawa and a master's degree in nursing administration from the University of Montreal, as well as wide experience in nursing in a variety of hospital settings. She is active on professional associations at both the national and provincial level. Rodger will assume her duties on February 1, 1981.

### Canadian Nurses Foundation

At this year's meeting of the Canadian Nurses Foundation, president Louise Tod issued a challenge to membership, a challenge of increasing the General Trust Fund to one million dollars by 1982. "The interest accrued from such a sum would support an administrative structure and a healthy and stable scholarship program," Tod said. However, to achieve this goal CNF will have to continue to increase Canadian nurses' awareness of and commitment to the foundation. While membership

has increased over the past three years, it currently stands at only 535 as compared to 1441 in 1970 (or 1311 in 1969).

The Virginia Lindabury fellowship is now a reality and will be offered in perpetuity as donations already have surpassed the \$30,000 mark. The first of the yearly scholarships will be awarded next year. Contributions to the fund have come from both individuals and associations from across the country. At the time of the meeting, Jocelyn Hezekiah, on behalf of the Registered Nurses Association of Ontario presented CNF with a cheque from the RNAO, along with a photograph of the former editor of *The Canadian Nurse*.

A new board of directors was elected to serve the upcoming two-year term of office. Fabienne Fortin, Diane Pechuillis, Margaret McLean, Marvelle McPherson and Margaret Arklie will determine the executive structure at their first meeting.



From sea to shining sea, St. John's, Nfld. in 1982! Marg McLean, retiring ARNN president, invited CNA members to their next biennium.



# RESOLUTIONS RESOLUTIONS RESOLUTIONS RESOLUTIONS RESOLUTIONS RESOLUTIONS RESOLUTIONS

## Nursing administration

*Resolved that the CNA publicly reaffirm its belief that the executive responsible for the department of nursing shall be an educationally qualified registered nurse who shall be a member of the senior hospital administrative staff, reporting directly to the chief executive officer.*

*Resolved that the CNA request the Canadian Council on Hospital Accreditation to emphasize the above standard which is stated in Standard Number Two under Nursing Services section of the Guide to Hospital Accreditation 1977, as a basis for rating nursing departments.*

*Resolved that CNA hold a national forum for nurse administrators on powers and responsibilities related to nursing management during the 1980-82 biennium.*

*Resolved that CNA study the issues inherent in the education of nurses for nursing administration.*

## Entry to practice

*Resolved that the CNA establish as a priority for the next biennium the development of a statement concerning the minimal educational requirement for entry into the practice of nursing in Canada.*

## Continuing education

*Resolved that the board of directors of the CNA study the issues inherent in continuing education for nurses and produce a position paper on continuing education for registered nurses in Canada during the 1980-82 biennium.*

## Certification of specialists

*Resolved that the CNA study the feasibility of developing examinations for certification in major nursing specialties.*

Spirited debate and informed participation marked many of the sessions of this year's CNA convention. At no time was this interest more pronounced than during discussion of the resolutions. Fifteen resolutions, plus two motions, were voted on; all but two were approved. Judging by the content of these resolutions, a 'short list' of contemporary nursing concerns in Canada would begin with the following five topics:

- nursing administration
- entry to practice
- continuing education
- certification of specialists
- independent practice.

The resolutions dealing with these concerns, like all resolutions approved by the voting delegates, will be taken under advisement by CNA's newly elected executive committee and directors of the association. Their action in implementing the resolutions will form the basis for association programs, projects and priorities over the next biennium. The resolutions are as follows:

## Independent practice

*Resolved that the CNA go on record as favoring the concept that independent nursing services provided to clients by professional nurses be eligible for compensatory coverage in provincial health care plans.*

## Other resolutions

Members also directed the association to:

- sponsor a second national forum on nursing education with a focus on clinical aspects of nursing education
- express the concern of its members over infant formula promotion practices in the Third World by supporting a boycott of these products

- promote use of the Health and Welfare Canada awareness kit, "Breastfeeding", as a teaching tool for RN's
- promote efforts to establish an Occupational Health Nurse consultant service at the federal level
- lobby to have dangerous household chemicals packaged in child-resistant containers
- support the National Council of Women of Canada in their efforts to have the Income Tax Act amended to allow wage earners to deduct from their taxable income money spent on continuing education courses for non-earning spouses.

## Fee structure

A motion that the association set up a working party to "study and develop a plan with regard to the issues of equitable representation and the annual unit fee of member associations in CNA" was also approved. The motion followed discussion of a resolution urging that the "ceiling" on fees paid by any one provincial/territorial association member be revised downward from the current maximum of *one third* of CNA fee income for the previous year, to a maximum of *one fifth* of that total.

The resolution, which originated with l'Ordre des infirmières et infirmiers du Québec, pointed out that the annual OIIQ contribution to the national association budget has reached the present ceiling three times in the past five years and requested that "its financial contributions be more proportionate to its true representation within CNA." Membership in the OIIQ now stands at close to 48,000; total CNA membership is approximately 127,700. ♡



*All convention photos by B.C. Jennings, Vancouver.*



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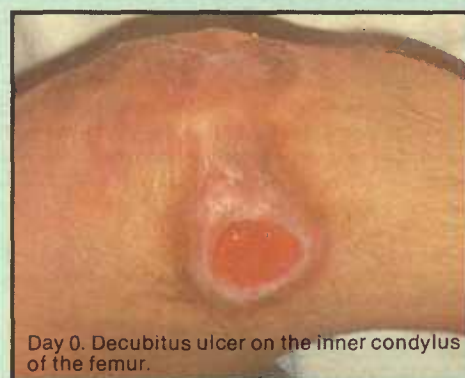


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**Day 4.** Conventional dressing changed twice.



**Day 5.** Conventional dressing changed twice.



**Day 6.** Conventional dressing changed twice.



**Day 7.** Conventional dressing changed twice.



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**Day 7.** Ulcer almost closed.

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1. Winter, G.D.: Healing of Skin Wounds and the Influence of Dressings on the Repair Process—Surgical Dressings and Wound Healing. Harkiss, K.J. (Ed.), Bradford University Press, 1971.



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# The role of the nurse-manager in labor relations

Glenna Rowsell

The level or group of nurses who are to be considered nurse-managers is established at the time of certification of the bargaining unit. During the certification process, the labor relations board determines who is not eligible for inclusion in the bargaining unit, based on their managerial or confidential functions. Although specific criteria may differ from province to province as well as within each province, all labor relations boards consider the employee in light of his or her authority to employ, suspend or discharge other employees in the unit, either directly or by effective recommendations, his or her authority to discipline employees and his or her position as it relates to confidentiality in the labor relations process and involvement in the grievance procedure.

Although employers often try to have as many nurses as possible excluded from the bargaining unit on the basis that their roles are managerial in function, the majority of nurses fight to remain part of the unit, since once they are excluded, they lose the legal protection and job security of the collective agreement.

Nurse-managers are the implementors of the collective agreement within the work-setting. However, with the exception of the director of nursing, few nurse-managers ever participate in the negotiation process. As it is at the bargaining table that the intent and implementation of the contract clauses are discussed and agreed upon, the members of the negotiating committee must provide a complete interpretation of the contract to the nurse-managers. This additional knowledge allows for more efficient and trouble-free application of the contract.

#### Working within a contract

Knowledge of discussions at the bargaining table must be accompanied by a thorough knowledge of the contract if day to day problems are to be resolved quickly. This also includes encouraging staff to become familiar with the contract and its contents. For the nurse-manager who is feeling uncomfortable with her role in coping

with a contract and a bargaining unit, seminars and workshops on labor relations may help in alleviating her problems and assist her in becoming more skillful in her role.

The nurse-manager plays a major role in handling day-to-day grievances. This involves developing an understanding of the employees as well as of the collective agreement under which they work. A genuine interest in the employees allows the nurse-manager to understand their needs more clearly and enables her to more readily identify the root of their problems.

#### Grievance management

Grievances must be presented in the manner outlined in the collective agreement. The specific grievance procedure involves a number of steps and a stipulated time frame. Grievances may fall in one of three categories: failure to carry out the terms of the agreement, a discipline grievance, or a general application grievance which has an impact on more than one employee.

Since a more harmonious union-management relationship can be anticipated when grievances are resolved in the early stages of the grievance procedure, management nurses must not be reluctant to become involved in resolving the problem.<sup>1</sup> Although there is no specific method for eliminating grievances, there are many basic guidelines which can minimize their number, frequency and magnitude.

Some stumbling blocks to grievance handling include:<sup>2</sup>

- *no plan of action* – intuition has no place in grievance handling, lack of an identified plan of action may cause more difficulties than already exist.
- *less than complete knowledge of the agreement* – nurse-managers who are not fully aware of the contents of the union contract or what constitutes hospital policy should not pretend to be experts; rather than give the wrong interpretation, check the facts.
- *failure to investigate* – analyzing the grievance requires investigation of the situation; deciding without investigation is a disastrous route.
- *failure to interpret facts correctly* –

subjective interpretations are counter-productive, analysis of a specific grievance with unique characteristics requires the nurse-manager to have an open mind.

- *reliance on pat solutions* – stereotyped handling of grievances can be disastrous as yesterday's solutions may not adequately solve today's problems. Effective managers check precedents but do not allow previous solutions to interfere in a unique situation requiring a unique solution.
- *failure to sell a decision* – explaining the reason behind the decision is just as important as the decision-making. A sympathetic "no" can be more productive than a harsh "yes".
- *procrastination* – festering grievances are one of the chief causes of confrontation; employees have long memories about injustices, real or imagined.
- *failure to anticipate problems* – effective nurse-managers anticipate resistance and concerns and mitigate against such reactions with appropriate communication and behavior.

Management nurses who establish a healthy relationship with their staff can resolve many grievances before they reach the formal grievance stage and in turn increase productivity. A little bit of attention initially when problems are small and frequently easily resolved, goes further than a great deal of hurried, stressful and pressured attention later on. Most complaints can be satisfactorily resolved by management before they become formal grievances.

If a grievance is not settled at the final stage of the grievance procedure, it goes to rights arbitration or adjudication, where a neutral party decides the facts of the case. The arbitrator or arbitration board's award is final and binding on both parties. If the grievance is an alleged violation of the agreement by the employer, it is the responsibility of the union to prove that the employer violated a section(s) of the contract. Similarly in the case of suspension or dismissal of an employee, the employer must prove that the employee was dismissed or suspended



for just cause. If the termination occurred during the probationary period, the employee does not usually have recourse to the grievance procedure.

### Documentation

Since in the case of suspension or dismissal of an employee the employer must prove just cause before the arbitration board, the responsibility of documentation usually falls upon the nurse-manager. The arbitration board will not accept second hand information of what management "thought" happened as evidence. Incidents of unsafe nursing care, insubordination, and so on, must be documented by the supervisor, discussed with the nurse in question and filed.

Once an employee has been warned of an impending dismissal, the nurse-manager must make sure she knows the following:

- *who* is involved, the employee's full name, the department, branch or division, the employee's position, title and job classification, as well as any witnesses concerned in the case or anyone else involved,
- *what* happened, including *all* of the incidents that occurred from the time a problem was suspected,
- *when* the act or omissions took place, including times, dates, frequency and over what period of time,
- *where* the incident took place, the exact locations (the diversity of areas may be important),
- *why* the problem exists, whether the employer violated the Labour Relations Act, a department regulation or a personal right; the employer must be prepared to justify the "why", and finally,
- *what* you want to accomplish, if it is suspension, the length must be determined and justified.

Remember, cases can be lost if management does not document the facts, fails to warn an employee that she is not meeting the standards or if regular written evaluations are not completed, signed by the employee and filed in her personal file.

### Achieving a voice in the system

While the nurse-manager's ability to achieve a voice in the system reflects the responsibility delegated by administration, it is also dependent upon her ability to accept responsibility and authority. Delegation of responsibility without authority to act can place the nurse-manager in a very difficult position and every effort should be made to have the job description re-evaluated. On the other hand, nurse-managers may not assume the authority they are given, tending not to want to perform unpleasant tasks or make unpopular decisions but leave these to more senior adminis-

## THE COLLECTIVE BARGAINING PROCESS

### Certification

Labor acts in the provinces and federal jurisdictions are administered by labor relations boards which are responsible for the certification of bargaining agents. These boards have exclusive powers to determine matters such as:

- who is an employer and employee
- who is a member in good standing
- what constitutes a unit of employees appropriate for collective bargaining, and
- if the bargaining requirements of the statutes have been met.

In the majority of provinces, legislation dictates that an employer may not unilaterally alter wages, hours and conditions of employment of employees from the date when an application for certification is filed until the date when a decision is rendered by the labor relations board. All acts set forth limitations on employers and on employees or their unions regarding interference in each other's rights; violation of these rights is termed an unfair labor practice or simply, an unfair practice.

### Negotiations

Once a union has been certified as a bargaining agent, legislated obligations are placed on the parties concerned, the employer and the union, to bargain collectively in order to conclude a written agreement covering salaries and other conditions of employment. In all labor relations acts ground rules are laid down for newly certified bargaining agents. Legal requirements for negotiations include:

- a notice to bargain,
- time limits in which the parties are to meet,
- representatives of the parties,
- circumstances which may interrupt or suspend bargaining,
- procedures to follow when one of the parties to bargaining changes,
- restrictions on employers during bargaining, and
- enforcement of the bargaining requirements.

One of the basic principles underlying negotiations is that the parties sit at the bargaining table as equals. Strategies are prepared by both parties before collective bargaining begins with their demands representing the bargaining objectives of their members (this applies equally to the employers team if more than one institution or agency is being represented).

"Bargaining in good faith" is a basic and essential element of collective bargaining and occurs when both parties make every reasonable effort to effect a collective agreement. Communications is another important element as both parties must be able to present their views and in turn listen to those of their opponent. There must also be a willingness to compromise; each party to the agreement must be willing to give something up during the negotiation process.

If a contract is negotiated and accepted by the employer and the union, it is signed by both parties and is binding until the expiration of the agreement. However if negotiations break down, there are various degrees of government intervention outlined in the labor acts before a legal work stoppage may take place.

### Mediation/Conciliation

Mediation and conciliation are regarded as equivalent terms referring to essentially the same kind of third party intervention used to promote the voluntary settlement of disputes, a process of peace-making.

A conciliation officer, appointed by the local labor relations board, meets with the parties and attempts to assist them in settling their stalemate within the negotiating process. The parties may also ask for a conciliation board made up of a neutral chairman, and one employer and one employee representative; this is sometimes called second stage conciliation. The award of the conciliation officer or board is not binding on either party. If both parties agree then a contract is signed, but if the parties reject the award and fail to reach an agreement, the next step is either strike or arbitration.

### Arbitration/Strikes/Lockouts

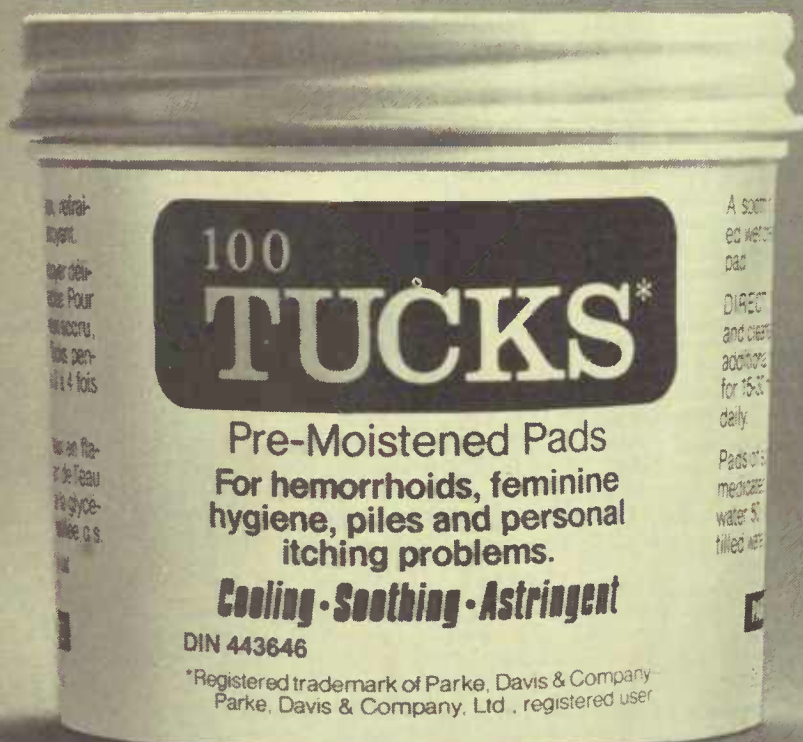
Two types of arbitration exist for use in the collective bargaining process. Interest arbitration is used when negotiations break down and the conciliation process fails to bring the parties together. Rights arbitration is used to deal with grievances which have not been settled during the grievance procedure. With the exception of Ontario, all labor acts do not provide for arbitration. Consequently, if this avenue is not open a strike vote and a possible strike follow.

All civil or public servants who are covered by public service labor acts have the right to choose the arbitration or strike route. If the strike route is chosen, the majority of these employees are covered by essential service legislation which gives the employer the right to negotiate the number of employees who will have to remain at work if a strike is called. A strike vote must precede a legal strike and if a majority vote is received, a notice of intent to strike must be given. The period of time required between the vote and the actual strike is stipulated by the appropriate labor act which also provides for a continuity of employee status during the strike.

A lockout of employees requires a vote where more than one employer is involved in the same negotiations or a vote of the board where only a single employer is involved. Although the majority of statutes prohibit work stoppages including lockouts during the term of an agreement, it is common to negotiate a clause in the collective agreement which prohibits the employee to strike and the employer to lock out during the life of the collective agreement.



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trative officers, effectively minimizing their impact and input into the system.

The nurse-manager *can* have a voice in the system if she is prepared to accept her responsibilities, keep up-to-date in all aspects of her work and present a positive approach to all decisions. She must accept the authority she is given and use it in the improvement of her services.

## The nurse-manager as a non-unionized employee

Québec is the only province with a management nurses union, and nurses in this province have succeeded in negotiating individual contracts. Management nurses who do not have the protection of a contract have no recourse to grievance and arbitration procedures and depend solely on a good employer to provide fair and equitable benefits. Although all employers must meet minimum standards set out by provincial Employment Standards Acts, the majority of employers provide greater benefits than are legislated.

Management nurses who are non-unionized workers, may find themselves behind the unionized nurses in benefits and salaries. Since they are not in a negotiating position, they must depend on administrations' decisions to increase salaries and benefits in an attempt to maintain a realistic relationship with those who work under their supervision. Recently, however, several cases have been reported where staff nurses are earning more than management nurses, including directors of nursing working in the same small institution. As a result, in some areas, management nurses have organized in groups to discuss problems of mutual concern. Others are seeking voluntary recognition with their employers in an attempt to negotiate changes in salaries and working conditions. ❖

## \*References

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- 2 Black, James Menzies; Black, Virginia Todd. *The front-line manager's problem solver*. New York: McGraw-Hill; 1963: p.242-244.

## \*Not verified

Nurses unions, professional associations and YOU" is a two-part special feature in the July/August and September issues of CNJ. The series is based on a chapter prepared by author Glenna Rowsell for a new textbook for nurse managers, "Nursing Unit Administration, first edition", released in June and available from the Nursing Unit Administration Program, 410 Laurier Avenue West, Suite 800, Ottawa, Ontario, K1R 7T6.





# Malignant Hyperthermia need not be lethal

Elizabeth Noble

Malignant hyperthermia, with its propensity for killing healthy, muscular athletes, is a relatively new disease in the medical world. Identified only 17 years ago, malignant hyperthermia (MH) remains frequently unrecognized and difficult to treat with a fatality rate still exceeding 50 per cent. Although this genetically determined condition is often considered to be a hazard only under the conditions of a general anesthetic in a large operating room, it should also be anticipated during local anesthesia in the dentist's chair, after conduction anesthesia for childbirth and on the playing field during an athletic event.

Susceptibility seems to be related to muscle bulk, strength and activity and consequently definite age and sex differences have been noted in victims. Males are more commonly affected than females, particularly between puberty and 30 years of age; MH is rare in adults over 50 and in infants under the age of two.

Although not diagnostic of MH, a number of clinical musculoskeletal abnormalities are more common in malignant hyperthermia susceptible (MHS) individuals than in normal persons. These MHS individuals tend to be emotionally tense and hyperactive, they may have been dyslexic in childhood, their muscles are strong at the beginning of exercise but they fatigue rapidly and they may exhibit mild localized weaknesses such as: strabismus, ptosis, lumbar lordosis and club foot. Some may also present with hernias (slipped discs, inguinal, umbilical or hiatal hernias), joint hypermobility with frequent joint dislocations (spontaneous or with minimal trauma), ecchymosis (bruising), prolonged bleeding after injury and frequent and severe epistaxis and poor dental enamel with many caries.

## A pharmacogenetic disease

MH is a true pharmacogenetic disease, as triggering drugs and/or stresses, as well as MH genes, are necessary for the development of an anesthetic crisis (*see figure one*).

During anesthesia, MH reactions may be precipitated by the following drugs:

- **potent inhalational agents** including halothane (Fluothane®), methoxyflurane (Penthane®), enflurane (Ethrane®), diethyl ether (Ether), isoflurane, cyclopropane, trichloroethylene, fluoroxene and ethylene;
- **skeletal muscle relaxants** such as succinylcholine (Anectine®, Scoline® and Quelicin®), decamethonium, gallamine and d-Tubocurarine, and
- **amide local anesthetics** such as lidocaine (Lignocaine, Xylocaine®), mepivacaine (Carbocaine®), bupivacaine (Marcaine®) and procaine (Citanest®).



Figure one

## FACTORS CAPABLE OF PRECIPITATING AN MH REACTION

### *Within the operating theatre*

#### 1. Potent Inhalational Agents

Methoxyflurane  
Halothane  
Enflurane  
Isoflurane  
Trichloroethylene  
Fluoroxene  
Diethyl ether  
Ethylene  
Cyclopropane

#### 2. Skeletal Muscle Relaxants

Succinylcholine  
Decamethonium  
Gallamine  
d-Tubocurarine

#### 3. Local Anesthetics

Lidocaine  
Mepivacaine  
Bupivacaine  
Prilocaine

### *Outside the operating theatre*

Extreme emotional excitement  
High environmental temperature  
Mild infections  
Muscle injury and/or exercise

### *Aggravating factors*

Sympathomimetics  
Parasympatholytics  
Cardiac Glycosides  
Quinidine analogues  
Calcium salts  
Caffeine and Theophylline  
Ethyl Alcohol

Anesthetic induced MH reactions may be aggravated by stressful situations including pain and apprehension immediately prior to or after anesthesia, hypoxia, hypercapnia, metabolic acidosis, hypotension and tracheal irritation.

MH reactions may be further aggravated by such groups of drugs as:

- sympathomimetics, adrenergics such as epinephrine or Levophed®,
- parasympatholytics, cholinergic blocking agents such as atropine sulphate, propantheline bromide (Pro-banthine®) or belladonna leaf,
- cardiac glycosides such as digitalis,
- quinidine analogues,
- calcium salts,
- theophylline derivatives such as aminophylline,
- ethyl alcohol and caffeine.

Malignant hyperthermic reactions may also be precipitated by stressful situations which cause a release of endogenous catecholamines such as epinephrine and norepinephrine. Extreme emotional excitement, high environmental temperatures, mild infections, muscle injury and exercise are all capable of this.

**The nature of the biochemical defect**  
The immediate cause of a malignant hyperthermia crisis is a sudden increase in the concentration of calcium in the muscle myoplasm (cytoplasm). This increase is induced by the direct or indirect action of triggering agents on the sarcoplasmic reticulum (SR) which are calcium storing organelles (sacs) lying within the muscle myoplasm. Their function is to take up calcium from the myoplasm during muscle contraction. Agents that trigger MH may activate a previously latent defect in the SR thereby rendering them incapable of taking up calcium from the myoplasm during relaxation and increasing the rate of release of calcium to the myoplasm during contraction. The net result is a marked increase in the concentration of calcium of the myoplasm.

This elevated myoplasmic calcium causes an increase of catabolic heat production in the muscle cell, an increase in the intensity and duration of muscle contraction and a decrease of the duration and completeness of muscle relaxation. For instance, a small rise in the concentration of myoplasmic calcium induces activation of the enzyme phosphorylase kinase which increases the rate of catabolism of glycogen to lactic acid, carbon dioxide and heat as well as increase the rate of consumption of oxygen in the mitochondria. Consequently a mild MH crisis leads to respiratory and metabolic acidosis, fever and hypoxia but no muscle contracture.

A greater rise in the concentration of myoplasmic calcium has two additional effects both of which increase and prolong muscle contraction. First, calcium activates the enzyme ATPase which causes hydrolysis of ATP to ADP and phosphorus and produces free heat and energy. This energy is utilized for muscle contraction, for the sliding of myosin (a

myofibril which is a short, thick rod) over actin (a second myofibril which is a thin coiled spring) to form short and rigid actomyosin. Secondly, calcium inhibits troponin, a third myofibril which is a long strand lying within the helices of actin. Troponin on combination with calcium becomes broken up into a series of short segments between which are open gaps. Through these gaps, cross bridges on the heads of myosin reach out to join receptors on the actin. These cross bridges move from one receptor to the next in a ratchet-like fashion, enabling myosin to slide over actin to form actomyosin in which myosin and actin, instead of lying end on end (as in the relaxed state) now lie side by side.

In normal individuals, alternation between muscle contraction and relaxation is cyclical. Relaxation follows contraction with the aid of ATP (but not its hydrolysis) when myoplasmic calcium falls below a critical threshold level, usually  $5 \times 10^{-7}$  M, and contraction recurs with the aid of ATP hydrolysis when myoplasmic calcium again rises above this threshold level. During an MH reaction, however, the myoplasmic calcium concentration remains permanently above the threshold level and so relaxation cannot occur.

As calcium rises to really toxic heights in the myoplasm during prolonged, untreated MH reactions, some of the excess calcium seeps into the by now leaky mitochondria. Here it uncouples oxidative phosphorylation from electron transport in such a way as to accelerate oxygen consumption and heat, lactic acid, carbon dioxide and water production but to inhibit ATP formation. ATP is the cells' refined fuel and is vitally essential for all cell work, not only muscle contraction and relaxation but also transport of ions across cell membranes. The result, therefore of inhibition of ATP formation and acceleration of ATP hydrolysis (utilization) is a fall in the concentration of ATP in the muscle cell. Consequently, there is a further decrease in the ability of the muscle to relax and a diminution in the rate of active pumping of ions across cell membranes. Instead, ions simply follow their natural concentration gradients. For instance, uptake of calcium into the SR, an active process against a concentration gradient, is further inhibited, while calcium release from the SR, a passive process with a concentration gradient, is to an even greater extent increased.



Figure two

## EFFECTS OF CAFFEINE AND HALOTHANE ON NORMAL, MHS AND MH MUSCLE

	Caffeine alone added	Halothane alone added	Caffeine plus Halothane
Normal muscle	1.0 gm increase in tension is seen with 4.1 mm of caffeine	no increase in tension	increase in muscle tension with 1.2 mm of caffeine
Nonrigid MHS muscle	no increase in tension even at highest dose	no increase	no increase
Type I rigid MH muscle	greater than normal increase in tension	greater than normal increase in tension	greater than normal increase in tension
Type II rigid MH muscle	greater than normal increase in tension	no increase	greater than normal increase in tension
Type III rigid MH muscle	no increase	no increase	greater than normal increase in tension

Similarly ions which are normally in higher concentration inside than outside the muscle cell, i.e. potassium, magnesium and phosphorus, leak from the interior of the muscle cell to the extracellular fluid. Conversely, sodium and calcium, ions whose concentration gradients are in the opposite direction, leak inward. This inward leakage of calcium, further aggravates the already pre-existing biochemical dearrangements within the muscle cell. Somewhat later large molecules such as myoglobin and muscle enzymes including creatine kinase and glutamic oxalic transaminase, escape across the by now incompetent sarcolemmal membrane.

As platelets are really floating muscle cells with many components similar, if not identical, to those of skeletal muscle cells, it is not surprising that these problems are reflected in their functioning as well. Once the normal functioning of platelets becomes disordered during an MH reaction, clotting ceases and the patient dies from hemorrhage.

#### Preanesthetic diagnosis of MH

A skeletal muscle biopsy is necessary to diagnose the MH trait. As an anesthetic technique that is both safe for MHS individuals and that does not alter the muscle must be used, a mixture of Innovar® (droperidol plus fentanyl), diazepam and nitrous oxide is commonly used. Muscle is removed from the vastus lateralis, a muscle lying on the front of the thigh.

In the laboratory, the muscle sample is carefully divided into small strips or fascicles. These are isometrically mounted between a plastic frame and a force transducer in baths of Kreb's Ringer solution which are maintained at 37°C. The transducer is attached to a Grass® polygraph on which is recorded the tensions (contractures) exhibited by the muscle fascicles. Six muscle strips are examined. To the bathing solutions surrounding the first two are added incremental doses of caffeine, to the second two, 1.0 vol% halothane and to the third pair, 1.0 vol% halothane plus incremental doses of caffeine. Caffeine is used as it is known to cause release of calcium from the SR and as well inhibit uptake of calcium into the SR. Halothane is employed as it is a drug known to trigger MH reactions.

Depending on the tension responses of the muscle the patients are classified as normal, as non rigid or as rigid. Three subgroupings of rigid MH may also be discerned and categorized as types I, II and III, ranging from the most to the least severe (*see Figure two*).

#### Clinical signs of an MH reaction

An MH crisis can occur at any time during anesthesia from induction until several days post operatively. The first evidence of a reaction is usually a tachycardia or other rapid, multifocal ventricular arrhythmia, the blood pressure then becomes unstable and respirations increase in rate and depth. The anesthetic tubing becomes extremely hot and the soda lime exhibits excessive discoloration and heat. The skin may at first turn bright red and then mottled blue. Rigidity of the jaw muscles may occur initially and later generalized skeletal muscle stiffness ensues although a few patients (called non rigid) never manifest any increase in muscle tone. Because the heart is a muscle it may also display stiffness and eventually fail. The urine may turn a reddish brown due to the presence of muscle myoglobin. Fever develops as a result, not as a cause, of the reaction and is therefore a relatively late event. The patient's temperature may rise 1°C per minute and attain values of up to 46°C or more. While death has occurred when maximum temperature elevations have been fairly low, survival has occurred after a fever of 44°C.



**Roy Healey**, a previously healthy 32-year-old male was admitted to hospital for a lung biopsy. In the operating room, induction was commenced with thiopentothal, succinylcholine drip and pavulon. Approximately 15 minutes after induction his blood pressure increased, his heart rate increased in rate and his skin felt hot. At this time his temperature was 39°C rectally. At 20 minutes, ventricular tachycardia was noted and treated with a bolus of Lidocaine 2% 50 mg. Mr. Healey was packed in ice and the operation was continued. Despite the ice packing his temperature rose to 41.4°C over the next twenty minutes and remained at that reading for the following thirty minutes. The operation was concluded in two hours at which time the temperature remained at 41.4°C and the heart rate continued to increase.

Five minutes after the anaesthetic had been discontinued and the operation completed, Mr. Healey suffered a cardiac arrest and had increased bleeding noted in his thoracic secretions as well as bleeding from his other body orifices. Closed cardiac massage resulted in a reasonable heart rate. He was treated with heparin, protamine, cardiac glucosides and sodium bicarbonate.

In another 25 minutes Mr. Healey suffered a second cardiac arrest with complete asystolic and an isoelectric electrocardiogram. At this time he was put on a cardiopulmonary bypass. As he continued to hemorrhage, his chest was surgically opened and sutures were used to ligate the hemorrhaging vessels and chest tubes were inserted. A tracheostomy was performed and he was connected to a respirator. We estimated that he had lost two to three liters of blood.

During this reaction, Mr. Healey's LDH isoenzymes increased three to five times, causing skeletal muscle damage. After one hour his temperature began to decrease and fell rapidly to 30.4°C, at which point he had to be warmed.

For two weeks Mr. Healey was comatose and his pupils were fixed and dilated, but he began to regain consciousness slowly. He was weaned off the respirator gradually and was found to have severe cerebral deficits including a partial paralysis of his left side, difficulty with speech and loss of memory.

When malignant hyperthermia was investigated, the muscle biopsy at 37°C revealed: a one gram tension level in the muscle with 0.23mM of caffeine (normal is 4.1-17.5mM) and a one gram increase in muscle tension was noted with 1.1mM of caffeine plus halothane (normal is 1.1-2.1mM); positive for rigid malignant hyperthermia.

**Greg Brand**, a healthy 43-year-old male, was competing in a six mile road race with his local running club on a sunny May morning. He felt relaxed and well during the early part of the race, but remembers nothing between then and the time he awoke in hospital a few days later. What Greg doesn't recall is that he collapsed during the race in a very cyanotic and febrile state. Wrapped in ice water soaked towels, he was rushed to hospital by ambulance.

On arrival at the Emergency Room, Greg was in an agitated comatose state with a temperature of 42.2°C. The diagnosis given was heat stroke. Blood tests revealed markedly elevated LDH and GOT levels and a CPK of 10,000 units (normal male level is 30-160 units). Within two days, his kidney functioning had deteriorated to the point where renal failure was a reality. Initially, hemodialysis was used but when the problem was not corrected immediately, a program of peritoneal dialysis was established and was necessary for a period of two weeks. During the days after admission, Greg's consciousness levels improved; he complained of severe muscle soreness and weakness. In total, he was hospitalized for seven weeks, losing 30 pounds over this period but on discharge his prognosis was excellent.

Over the years, Greg had undergone several uneventful operations and anaesthetics. This was the only occasion which indicated a potential for malignant hyperthermia. This was confirmed when a muscle biopsy at 37°C revealed a one gram tension level in the muscle with 4.4mM of caffeine (normal is 4.1-17.5mM) but with caffeine plus halothane, a one gram increase in muscle tension was noted with 0.57mM (normal is 1.1 to 2.1mM). Rigid malignant hyperthermia was diagnosed.

Early laboratory findings include a combined respiratory and metabolic acidosis due to elevated lactic acid and carbon dioxide production in the muscles; arterial pH therefore falls to a very low level. Increases in serum creatinine and myoglobin develop several hours after the onset of the reaction and finally massive elevations of muscle enzymes (CK and GOT) develop in the serum.

A prolonged and fulminant MH reaction may lead to:

- acute renal failure secondary to myoglobinuria,
- acute pulmonary edema and ventricular fibrillation secondary to rigor of the heart muscle,
- generalized bleeding from body orifices, wound and needle sites secondary to depletion of platelets, fibrinogen and other clotting factors and
- cerebral dysfunction with associated cerebral edema.

#### Treatment of acute reactions

Recognition of an MH reaction is the single most important factor in ensuring the patient's survival. The time to recognize a reaction is during the first few minutes for within this precious time, awareness and speed may be lifesaving. All vital signs, including temperature, pulse rate, blood pressure, respirations and electrocardiogram, therefore should be monitored during and after every anesthetic. If the temperature rises by more than 1°C a diagnosis of MH should be entertained.

Once a reaction is suspected ALL triggering anesthetic agents must be discontinued immediately and the surgery terminated as soon as practicable. The rubber tubing and bags and soda lime should be changed for new and unused equipment to ensure total removal of lipid soluble anesthetic vapors from the gas machine. To return blood oxygen and carbon dioxide tensions to normal the patient must be hyperventilated with a gas mixture containing 50 to 70 per cent oxygen. Enough sodium bicarbonate should be infused to about half correct the metabolic acidosis. Vigorous cooling measures may be necessary to achieve significant temperature reductions. Thus, in addition to external cooling with cooling blankets and ice water baths, internal cooling with cold intravenous solutions and irrigation of body cavities (stomach,



## GENETIC TRANSMISSION OF MALIGNANT HYPERTHERMIA

Malignant hyperthermia (MH) is a hereditary trait as transmission is due to one pair of autosomal dominant genes, sometimes in combination with one or more pairs of weak recessive genes. When one or both parents possess both dominant and recessive genes, the probabilities of MH inheritance become complex, with nine different possible gene combinations, including one normal, one carrier (someone who appears normal but who can pass the trait on to his or her offspring if the spouse also possesses a similar MH gene) and seven others with varying degrees of clinical MH abnormalities.

Even with normal parents, a new mutation may occur. This is often due to harmful exposure of the mother to radiation, drugs or viral infections such as the German measles during the first few weeks of pregnancy.

	one parent	both parents
One dominant MH gene	50% of offspring are MHS*	25% of offspring are severely MHS  50% of offspring are less severely MHS  25% of offspring are normal
Two dominant MH genes (one pair)	100% of offspring are MHS	100% of offspring are MHS
One recessive gene	25% of offspring are MH carriers	25% of offspring are MHS
Two recessive genes (one pair)	100% of offspring are MH carriers	100% of offspring are MHS

\*MHS Malignant Hyperthermia susceptible

rectum and abdomen) with sterile iced solutions may be necessary.

Medications effective in the treatment of an MH reaction include:

- chlorpromazine (Largactil®), a useful adjunct in lowering body temperature as it decreases heat production by inhibiting both shivering and non-shivering thermogenesis and increases heat loss by inducing peripheral vasodilation,
- propranolol (Inderal®), verapamil, procainamide (Pronestyl®) and diltiazem, effective in the treatment of cardiac arrhythmias as they prevent the release of calcium from the cardiac SR to the cardiac myoplasm and/or inhibit influx of extracellular fluid calcium across the cardiac sarcolemma into the myoplasm,
- dantrolene sodium (Dantrium®) which decreases the temperature and relaxes the skeletal muscles by preventing release of calcium from skeletal (but not cardiac) muscle SR,
- regular insulin in 50 per cent glucose, effective in lowering serum potassium early during the reaction,
- potassium chloride infusions may be substituted for the insulin therapy later when hypokalemia supervenes over hyperkalemia,
- furosemide (Lasix®) which facilitates removal of myoglobin from the renal tubules and corrects the sodium overload that is generally induced by the sodium bicarbonate therapy,

• mannitol, a free water diuretic, is also useful in overcoming the myoglobinuria as well as attenuating cerebral edema,

- hydrocortisone (Solu Cortef®) which may be of some value in stabilizing muscle cell membranes and in reducing cerebral edema, and
- heparin infusions, to retard the development of acute consumption coagulopathy, a therapy that is still not yet well proved.

### A brighter future

Research continues to be conducted into the cause of MH, in particular the nature of the SR defect. With more accurate causal theories, methods of diagnosis and treatment will become more refined. Already more accurate and less invasive diagnostic tests are being developed, tests that require only one single muscle cell. In the future, tests of platelet dysfunction may entirely obviate the need for any type of muscle biopsy. ❖

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My father, at 94, was dying. He was so far gone that he did not enjoy his food; his intake was practically nil. It was a hot summer day when I visited and I thought perhaps a glass of cold beer might tempt him to drink something. So I went out and bought some beer. When I brought it back to his room, it was taken from me: hospital policy did not permit liquor on the premises. Probably my father wouldn't have enjoyed that drink anyway but I'll never know.

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# A time to be born A time to die

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For years, our institutions, the people who administer them, the doctors and nurses who work in them; have conspired to rob dying patients of their individuality. Now the growing credibility of the hospice movement offers new hope of providing care that will "personalize" death, recognizing it as part of the individual's total experience of growth and development.

We see the hospice as providing a haven for the dying, a place where distressing symptoms and pain will be relieved. The hospice strives to recognize individuality in planning for care and death, whether the patient remains at home or enters the facility. Care is holistic, with particular attention to the mind and spirit as well as the body. "Intensive caring instead of intensive care"<sup>1</sup> is the central concept on which planning is based. Energies are directed to improving or at least maintaining quality of life, rather than prolonging survival through heroic measures. Care is provided in the setting of a homelike, congenial and protective community comprised of family members, staff, volunteers and members of the broader community. Personnel recognize the patient/family unit as being at the center of this service. During their bereavement, family members continue to receive this support.

Observation convinces me that there is general agreement on the desirability of these objectives; most of us realize that the best interests of the patient are not well served by existing methods of pain management and confrontation with death in the hospital setting. Why then have the objectives and assumptions of the hospice movement not become general practice long before now? Why are our dying, even today, often neglected? Perhaps we can benefit from our errors and omissions in the past if we look at them realistically and then use this evaluation as a stepping stone to implementing a new approach.

the case when the patient was one who confronted death in a hospital setting. When he was brought to hospital, even if he was still mobile, he was given a gown and put to bed. All his belongings were checked and removed from his room. Then he was expected to get on with the business of dying and, what's more, to go about it in a cooperative manner.

For the most part he was kept in ignorance; many uncomfortable, painful and sometimes unnecessary treatments were performed without explanation or permission. When death approached, he was continually disturbed to check for vital signs; nurses in those days certainly were well aware that the temperature reached 107° rectally and the patient's blood pressure dropped just before he died.

The nurse abetted the doctor in keeping the patient in the dark about his condition: naturally she couldn't divulge medical secrets. The physician was the person in charge and he would do the telling. Well, maybe not all, just enough to save the day. Families were not well informed either; they kept a stiff upper lip during their visits and tried to avoid discussing his illness with the patient. The patient saw through these maneuvers, of course, but respected the unwritten rules of the institution and, not wishing to be considered out-of-line or a troublemaker, conformed with the non-verbal request that he keep quiet. At the same time, he bottled up the panic, fear, guilt and other emotions arising from his situation. At a time when he should have been working openly towards a peaceful death, he was surrounded by evasion and denial.

Pain was not well handled. Medications were limited and controls were rigid. Morphine 15mgm, q4h, p.r.n. was the order of the day, even though this was often grossly and patently inadequate. You made the patient hold out "until it really hurts" because, after all, you didn't want to

## The acute care model

For years, professional disciplines in the health field have addressed themselves to curing; all our skills and concerns were channelled towards defying and defeating disease. Rewards were task-oriented. Care was given in an efficient, dispassionate and detached manner because we were taught that, as professionals, personal involvement and self-disclosure were in poor taste. Nurses actually experienced guilt and embarrassment if they were "caught" sitting in conversation with a patient. Personalities were kept concealed and the patient's problems buried so as not to create problems for the staff and the organization.

Naturally, attitudes such as these had definite and strong implications that were reflected in the kind of care that was provided. This was especially



make a dope fiend out of him or cause his condition to deteriorate. As a consequence, the patient was constantly on the bell since he was preoccupied with his severe pain and his need for the next needle. This pain kept him immobilized in bed, totally dependent on your care and a nuisance to all the staff.

To ensure that a patient's spiritual needs were met you checked his kardex and, if he happened to be of the Roman Catholic faith, sent for a priest. The priest came alone, carrying the necessary items, and performed the last rites behind drawn curtains. Clergy looked in briefly on other patients and left just as quickly so that they wouldn't upset them by causing them to believe that the end was approaching.

Families were considered a bother: their visiting hours were generally limited. It was difficult for nurses to assume the role of Florence Nightingale succoring to the dying in front of the whole family. You felt inadequate. It was also difficult to deal with the emotions of family members; small talk was a struggle and, besides, it kept you at the bedside when you had so much other work to do. Accommodation for visiting family members was often limited to two chairs; even husbands or wives were forbidden to sit on their dying spouse's bed. Recently, when my own husband was ill, the nurse who was caring for him asked me to get off the bed.

Finally, the person slipped quietly away, hopefully on someone else's shift, and you experienced a feeling of great relief if the family preferred not to be present or did not get there in time.

Mourners were asked to sign the necessary forms and then they left. The body was hastily prepared for the morgue and smuggled out of the room and down the hall after all the doors were closed. Closing the doors in itself told the story but if someone enquired you always denied that there had been a death on the floor. Death was not always so dispassionately treated, but often it was. Those who fared better had families who took the initiative. In recent years, I have had personal experience with some of these old rules and regulations: in each case, the heavy hand of bureaucracy came down when an act of human kindness should have been in evidence.

Old habits die hard and, as recently as 1976, a study carried out at the Royal Victoria Hospital in Montreal, showed that, even though educators began talking about "psychosocial care" in the forties, dehumanizing behavior is more often than not still the order of the day on busy surgical wards. R.W. Buckingham III was the participant observer in this study of the treatment, attitudes and interactions of hospital staff, terminally ill patients and their families.<sup>2</sup> During his hospitalization, he was frustrated by the lack of meaningful relationships he experienced: staff/patient contacts were mostly technical and brief. Interviews were rushed and restrictive: lengthy responses by patients were "tolerated" and, if the evidence was not strictly related to staff concerns, impatience on the part of the

care facilities. Acute care attitudes, philosophies, rules, regulations and rituals, transposed to a long term setting, just don't work. The fact that the term "vegetable" was coined is poignant testimony to this fact.

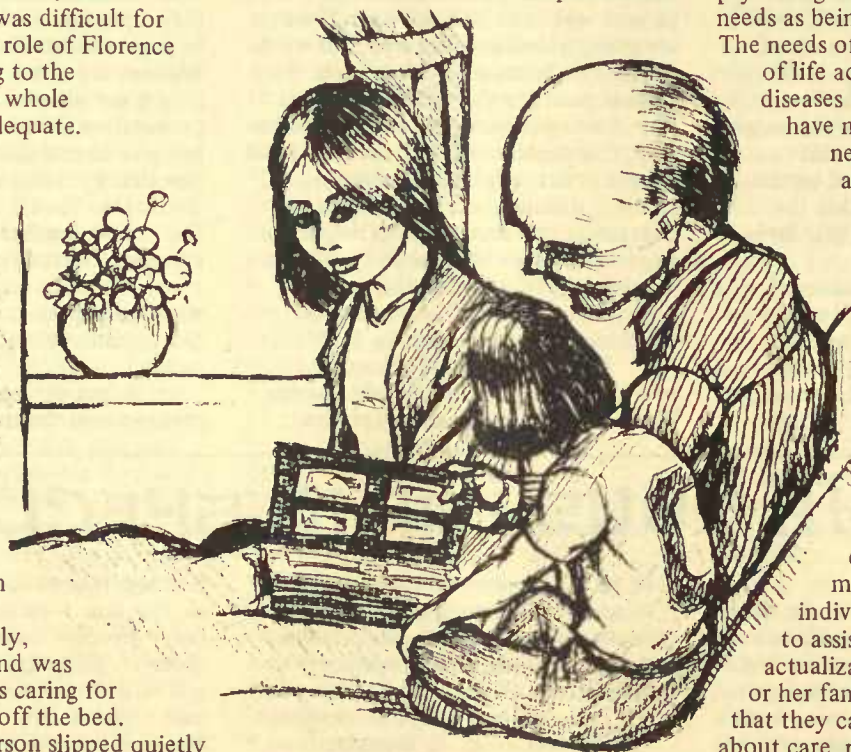
Noted gerontologist, Dr. Herbert Shore, is one who advocates the introduction of a psychosocial model of care for long term patients. His fundamental premise is that present long term institutional care is experiencing problems primarily because it is modeled after a hospital, measured by a criterion which is not only inappropriate, grossly inefficient and costly, but harmful as well.<sup>3</sup> A psychosocial model of care would not only provide excellent physical care, but would develop an holistic approach that views the person's psychological, social and spiritual needs as being of equal importance.

The needs of elders in their final phase of life accompanied by chronic diseases for which there are no cures have much in common with the needs of the dying at any age, that is, that the quality of life remaining meets the individual's needs.

Both long term care facilities and hospices, in the home or in an institution, should provide care adapted to the functional abilities, personal and emotional states, economic background, social status, religious persuasion, culture, past experiences and environmental exposures of the individual. Support is provided to assist the person to reach self-actualization. The client and his or her family is kept informed so that they can participate in decisions about care, preferences and intentions. Diversional recreational and occupational activities are provided to overcome monotony and provide the person with the opportunity of participating in useful endeavors. Religious services are provided to meet the needs of those who wish to participate. In both levels of care the clients will die but, in the hospice, death is imminent.

The hospice movement attempts to take us one step further: it shows us how to provide a more personal death by introducing specialized components. Incorporation of these will enhance the psychosocial model of care and can be applied in any facility because to a great degree they are attitudinal and philosophical concepts.

A "good death"  
How and when did our impersonal



questioner was evident. Frequently staff, including doctors, entered or left the room without recognizing by word or look, the people in it. Monotony and loneliness on the part of the patients was the rule rather than the exception. This behavior is not an isolated experience; it occurs throughout America.

**Custodial vs. therapeutic care**  
Whatever their age or personality type, whether they are in an acute or chronic care setting, persons subjected to impersonal, even rude behavior do not fare well. Their integrity suffers, they lose their identity and their spirit fails because they are not allowed to integrate with their environment.

We know the effects of this "hospital-type", custodial care on the elders allowed to languish in long term



attitudes towards death and the dying patient develop? I believe it was because the dying process was taken out of the hands of the families and away from their support systems. Years ago, a person died at home surrounded by family, neighbors and clergy. When the dying were taken to the hospitals family support suffered because of the rules and regulations of the hospitals. Visiting hours were limited. Children were not allowed. I have seen a mother waving her last goodbyes through a window to her children on the street below. Care was taken out of the hands of family. The custom of holding wakes at home gradually stopped as the undertaker took over. The undertaker became more and more expert in easing the pain of the mourners, even to the point of camouflaging the earth. Gradually, mourners were pushed further and further away from the reality of death. Death was taken out of the hands of families and placed in the hands of strangers, albeit "professional" strangers. Cultural influences also came into play and these professionals contributed to the creation of certain myths, including the myth that the patient does not want to be told he is terminally ill.

Researchers have found up to 89 per cent of those surveyed report wanting to be told in the event that they become terminally ill.<sup>4,5</sup> Less than ten per cent indicate that they would resent this frankness.<sup>6</sup> A poll

of physicians revealed that the overwhelming majority would want to be informed in the event that they had an incurable disease.<sup>7</sup> But our doctors are also caught up in cultural apprehensions concerning death: more than half of these doctors were not in favor of telling a patient he was dying.

Vernon and Payne write: "When we refuse to recognize that the person is dying, or let him know we are aware of his dying behavior we impose an isolation on him; such agreed upon silence may increase the patient's fears and despair while at the same time cutting him off from the opportunity to reduce those anxieties through sympathetic discussions or some type of therapy. Some patients suffer more from emotional isolation and unwitting rejection than from the illness per se."<sup>8</sup> Can we deduce from this that the patient wishes to be told? And, if we are going to inform him, how will we do it? Sensitivity must be used. Each patient reacts to this news in his own way. Some patients may not wish to be told; this denial *must* be respected. Most people at first experience an emotional storm — denial, grief, fear, bargaining, depression and acceptance. The patient experiences each of these in turn, with varying degrees of intensity, until hopefully acceptance occurs and he becomes resigned to his own death.

While I was still at school, my previously healthy 25-year-old brother was brought in dying of a ruptured

appendix. Surgery was performed, to no avail. My sister, a nun, and a nurse, told him so and he said, "God can't do this to me," but within five days he achieved resignation and died peacefully. The last thing he said was, "I am happy now."

The doctor needs to give the team freedom to discuss the patient's condition frankly with that patient, so as to erase hesitations which could be construed in a negative way. Nurses must also have the right to adjust medications to need so that they do not unwillingly contribute to pain and anxiety. The patient should also have the privilege of going home for visits without the need for continuous orders. Being free of pain greatly assists the patient in dealing with death realistically and narcotics should therefore be given freely when required. Doctors and nurses may need to revise their opinions on this subject, and come to grips with the fact that drug dependency is not a problem so long as pain is not allowed to reach intense proportions. Nurses, who generally do not give large doses of narcotics, may fear that by doing so they may hasten death. One should think of the intent in this regard: medication is given for comfort. The required dose may be given conscientiously at prescribed intervals so that the patient can relax, knowing that intense pain will not be allowed to occur.

Along with good pain management the nurse gives excellent

## THE HOUSE OF RESPECT

*Barbara Devine*

A home for senior citizens where residents participate eagerly in their own maintenance—assisting with meals, feeding chickens, gardening, growing flowers and helping to care for their fellow residents who are less able? A home where other members of the community come and go freely and frequently — visiting, reading, playing chess with the residents?

A home that really is "homelike" — with bright, cheerful surroundings, shady areas outside set up with tables for chess and checkers and a reading room inside equipped with books, newspapers, TV, and, usually, a staff member to help out with reading sessions?

Sounds too good to be true? Not really because these were some of my observations during a brief visit to a senior citizens home in the People's Commune in Nanhuan, outside Peking, last year. This particular House of Respect is "home" for 100 residents. The staff

of 18, all members of the commune, include an administrator, three cooks and a barefoot doctor whose duties include the provision of meals, laundry services, working in the tailor's room where all clothing for the residents is manufactured and, generally, assisting in the care of the elderly residents. Rooms are set up for married couples, or for three or four residents. Sometimes, if requested, meals are served in rooms, but, more often, they are shared in the common dining area. Medical attention at the primary level is provided by the barefoot doctor who has had two years of medical training. Seriously ill residents are referred to the hospital. Food, clothing, medical care and all other expenses are shared by members of the commune.

In China, where 85 per cent of the people live in rural areas, the three-generation extended family continues to assume most of the responsibility for caring for older

persons. Homes for the elderly such as the one I visited usually house only people who do not have children. Older people who are able and wish to continue living in their own homes are free to do so. Members of the commune provide support systems to these elderly who wish to remain in their own village.

In a country which is attempting to build a new society, the elderly are made to feel they are an integral part of that society.

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basic care and treats each symptom as it appears so as to provide comfort. Freedom from pain and discomfort encourages mobility, participation in activities and often permits the patient to remain at home much longer than he otherwise would. It also allows him to work through his grief process and helps him get his "books" in order.

Living experiences must be offered at this time so that the person can experience quality of life suited to his needs for as long as he can enjoy this participation.

Robert Kastenbaum gives direction to the team on how to plan for death; he advocates a final care plan which makes death a "legitimate" outcome rather than an event which violates the norm.<sup>9</sup> The plan includes not only what should be done during the last days, but also the scene immediately after death — where it should be, who should be there, what should be done, all in the context of the person's cultural and religious beliefs, lifestyle and individual wishes. If the person wishes to make final arrangements regarding pallbearers and the funeral, you should not hesitate, but participate by assisting in their plans. Just remember, there is no *one* good death! Besides fearing the unknown, patients who are facing death fear abandonment by those close to them. Patients need to know that they will not be left alone and to feel secure in this knowledge. Relatives and close friends must always be made welcome; an area should be set aside for their rest and refreshment and should be pointed out to them. These mourners are going through a difficult time; their situation demands our kindness, consideration and counsel.

Often, people are uncomfortable because they do not know what to say in the presence of death. All of us have confronted this problem at one time or another. Sometimes, listening will provide the key. Remember, it isn't what is said that counts but how it is said. Often just being there is enough. Don't forget also, the importance of the outstretched hand...for touching, caressing and holding.

Clergy and church volunteers can provide valuable support and counsel. Readings from the Bible and prayer, religious rites and rituals, carried out at the patient's request, can also provide comfort to the patient. Always try to respect the wishes of the family members who want to remain involved to the end or wish to be left alone with the body after death occurs. In some hospices, death is not hidden: there are viewing rooms where the bodies remain for awhile so that families, staff and other patients can pay their respects. Memorial services can be held on the premises. Hospice personnel should be

encouraged to attend funeral services if possible.

Nor does caring stop with death: family members need support and counselling in both the early stages of their bereavement and later on. Three and twelve months are thought to be particularly difficult anniversaries.

### The hospice concept

To sum up, there exists today a real need for an imaginative and innovative approach to new concepts in caring for the terminally ill patient. This is particularly true at the management level but it affects all nurses. We need fresh air if we are going to succeed in providing a living environment for the dying at a price we can afford. We need personnel who can create a people-oriented, patient and family-centered atmosphere in whatever agency they work. Because they are attitudinal and philosophical in nature, many hospice concepts can be introduced in any agency where death occurs. Some of the principles to remember include the following:

- Hospices should function independently from other institutions to prevent the carryover of traditional attitudes, policies and practices.
- Regional teams whose members are experienced in the area should be available to provide education, inservice and consultation on:
  1. psychosocial models of care
  2. confronting death
  3. supporting the family during the dying process and bereavement
  4. good basic nursing care with pain control and symptomatic management
  5. a holistic approach to care.
- Personnel must come to grips with the fact that they are no longer concerned with saving a life; the priority is now on providing a good death without needless monitoring and procedures.
- Compassionate and intensive caring is crucial. This care must be available 24 hours a day, seven days a week, and must be supported by a network of resources that will permit needs to be met when they become evident since postponement can be pain wracking or emotionally devastating.
- Above all, there must be good pain management by a team of health care professionals that really is knowledgeable in this area. ❖

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Vera McIver, RN, has received international acclaim for her work in long term care for the elderly. When she became director of health services at four Juan de Fuca Society Hospitals in Victoria, B.C. in 1967, she established the Priory Method of helping the elderly, a method aimed at treating seniors as normal people rather than as sick patients. Now retired, she has given numerous lectures and published many articles on the method. Vera participated in the Canadian Council on Hospital Accreditation's "Appraisal of Long Term Excellence of Care Project for Development of Care Appraisal Manual" workshop in March 1979; she has also given workshops at the University of British Columbia on "The Priory Method — Implementation of a Psychosocial Model" and to the Pacific Gerontology Association on "Creating a Living Environment for the Dying". Other recent workshops on "The Implementation of a Psychosocial Model" have taken her across the country from the University of Calgary — Alberta Hospital to Summerside, Prince Edward Island, where she spoke to the Department of Health and Social Services. On the international scene, she presented "A New Organizational Model for Long Term Care" last May in Buffalo, New York. Currently Vera is a surveyor with the Canadian Council and a member of the Capital Regional Hospital and Health Planning Commission of Victoria.





Over the last 90 years, religion and sex seem to have reversed their positions. During the Victorian era spiritual matters were freely discussed in print and in speech, while sexuality was hardly recognized, let alone verbalized. However, in the last quarter of the 20th century we are experiencing quite a different situation, especially in the field of nursing. Sexuality has become a very common, if not prominent, area of content and concern for nurses while spirituality is at best treated with embarrassment or, even worse, ignored.

Why the embarrassment? Why the lack of recognition of such a pervasive, prevalent aspect of human life? Did not nursing historically develop in a religious milieu in which love of God and mankind was expressed through care, compassion and charity to the sick, the poor, the orphans and the outcasts? Have we become so secularized that we cannot even recognize that our patients' needs might be affected by spiritual beliefs? The Code of Ethics of the International Council of Nurses states: "The nurse, in providing care, promotes an environment in which the values, customs and spiritual beliefs of the individual are respected."<sup>1</sup>

Undoubtedly this statement implies more than the ascertainment of a patient's *religious preference* during admission procedures or the initial assessment; it means respecting his expression of his spiritual beliefs. I have heard nurses say the following:

- "You don't have to answer this, but, what is your religious preference?"
- "What relevance has religion to patient care?"
- "Religion has a devastating effect on sexuality."
- "I think it's terrible the way some sects brainwash their children!"

Such statements suggest not only discomfort with the topic of religion but a lack of understanding of the significance of religion in the lives of many people, gross generalization, and bias with regard to different spiritual beliefs and religious practices.

Census figures show that, in 1971, 95.69 per cent of Canadians who were asked "What is your religion?", named a religious preference. The Judeo-Christian religious denominations constituted 94.25 per cent of the total population, while 1.44 per cent was comprised of Buddhism, Confucianism and "others".<sup>2</sup> It must be noted that the above figures deal with nominal, not practiced religion since it is likely that individuals chose to name a religion rather than say "no religion".

Frankly speaking

# Whatever happened to the Spiritual Dimension?

Donelda Ellis

Frankl, who survived the horrors of the World War II concentration camps states, "man's main concern is not to gain pleasure or to avoid pain but rather to see a meaning in his life."<sup>7</sup> Frankl also sees the

## Giving meaning to life

Spiritual beliefs do abound and are a very vital component of the lives of many of our patients. When we limit our nursing assessment to the identification of the patient's religious affiliation we severely hamper our ability to provide the best care concerning the spiritual dimension. Since spiritual factors may profoundly affect a person's response to health, illness, crisis or death, it is the responsibility of the nurse in her assessment to determine what meaning a patient's spiritual beliefs have for *him*.

For many, illness is a time for reflection. "Patients have time to consider their past, their future and their values."<sup>3</sup> Where illness poses a threat to life, one may turn to his religion for spiritual support. As Gordon Allport notes, "...under conditions of fear, illness, bereavement, guilt, deprivation, insecurity, the restoration of values through religion is commonly sought."<sup>4</sup>

It is clear, therefore, that spirituality is not limited to such religious practices as adherence to dietary laws, communion, baptism, circumcision and the last rites, but is experienced as a relationship with God that "integrates one's life, vocation and relationships and gives them meaning."<sup>5</sup> Religion is defined as an organized system of worship which is characterized by the possession of beliefs which the person professes, norms of morality which regulate the conduct of the members of the system of religion and the rites and practices utilized in the system of worship. Spirituality, on the other hand, can be defined as the quality of having a dynamic and personal relationship with God. Although the most common forms of spiritual beliefs are founded in theology one cannot ignore the fact that religion can be atheistic. Jourard states that "Whatever a person takes to be the highest value in life can be regarded as his god, the focus and purpose of his time and life."<sup>6</sup> Every man needs a purpose in order to give his life meaning, and that meaning is a personally perceived phenomenon, whether it is related to a personal relationship with God, or a non theistic activating force.

Man also strives to find the meaning in his suffering and as Viktor

majority of patients as considering themselves accountable to God. "They represent those who do not interpret their own lives merely in terms of a task assigned to them but also in terms of the taskmaster who has assigned it to them."<sup>8</sup>

The relationship to this "highest value" and its associated beliefs provide a unifying and integrating force in the life of an individual and, therefore, cannot be ignored by the nurse who purports to be concerned with the whole person. The nurse must be prepared to assess the spiritual dimension and provide (for) spiritual help, which Piepgras states "may be regarded as distinct from either physical care or emotional support. Although it leads into new directions it is no less real and needs to be examined openly and discussed intellectually."<sup>9</sup>

## Assessment and approach

The spiritual dimension is not a separate department of an individual's life but an integrated and integrating force of the total person. The nurse can assess the individual's perception of how his spiritual beliefs influence the ways in which he attempts to satisfy basic human needs. To assess this area some guidelines are necessary; the following are suggested for your consideration.

- the assessment should be integrated with other forms of history/information methods
- the approach must be sensitive and based on a relationship of trust between the patient and nurse
- respect for silence or objection is essential
- questions require (1) an appropriate format as with other psychosocial areas and (2) language suitable and comfortable for both nurse and patient.

The assessment interview can elicit information about how the individual's spiritual beliefs affect his needs:

- 1 for achievement and purpose in life, e.g. how these beliefs determine use of time, money and talents
- 2 for love, a sense of belonging and dependence, e.g. source of solace in times of desolation
- 3 for feelings of self worth, e.g. factors that increase or decrease feelings of self esteem or the esteem of others including God



4 for feelings of safety, security, wholeness or integrity, e.g. source of help when feeling insecure, anxious or threatened

5 for sensory stimulation and satisfaction, e.g. degree of enjoyment of religious practices such as music, ceremonies, prayers, reading etc.<sup>10</sup>

Most questions could appropriately be posed while the nurse is giving physical care such as bathing or helping with a meal. Insensitive and poorly timed questions will lead to difficulties. Information can also be gathered through the observation of cues:

- a Star of David about the neck, religious literature or a rosary at the bedside
- spontaneous questions such as, "Why does God let this happen to me?" or statements such as "I'm afraid of dying."
- facial expressions indicating depression, fear, doubt or despair
- "The casual, and even amusing mention of God or religion to test out the nurse's reaction"<sup>11</sup> ...possibly indicating a cry for help.

The manner of the nurse is a significant influence on the quantity and quality of information obtained. Even though the nurse might not have a particular concern for spiritual life, this does not exclude her from the obligation to be aware of the patient's needs in this area. She needs to demonstrate empathy and non-judgmental understanding while assessing and carrying out nursing care, whether she intervenes directly or arranges for a lay person or a member of the clergy to provide spiritual support.

If the general goal of nursing is "holistic" care for individuals then we cannot deny the spiritual/religious dimension of the person. We must recognize the potential healing force of all aspects of the person's life. What sort of assistance can the nurse offer? Because of the variety of beliefs and practices it is difficult to be specific, however a few concrete examples are possible:

1. helping to arrange for solitude or privacy if necessary for prayer, meditation or other practices
2. being open to cues that indicate a desire to discuss spiritual concerns
3. arranging schedules of care to allow for visits of chaplain, rabbi or others
4. providing the necessary assistance for the patient to attend services.

Piepgas states: "Spiritual help is different from emotional support. Whereas the latter concerns itself with a relationship of a person to himself and his environment, the former concerns a person's relationship to a higher being. This relationship is personal and even though its concepts and the specific supporting philosophy may be shared by others, it is still an 'I-You or God-Man relationship'."<sup>12</sup>

## Conclusion

We give lip service to offering care to the total person, while consistently avoiding discussion of spiritual/religious matters. My contention is that we must become active in this domain. Our approach must be more intellectual, beginning with an attempt to understand the reasons for the present situation of neglect. From there we must incorporate methods of assessment and care into both our theory and practice. This must become a visible area of study and activity in nursing. ♡

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## DENIAL

Gisele Fontaine Kermer

He said it would be our last Christmas together. I thought it was because I was moving away.

He sent my sister all the family slides to divide between us. It struck me as a rather strange thing to do. I mean, why now?

He spent more time at home, thinking about the past and updating the family history. I didn't get letters about hockey games at the arena or dinners with friends, anymore.

He got the flu—the flu! They put him in hospital. He needed rest, that's all. He'd gotten well before and he would again. I knew that! After all, I was the nurse...wasn't I?

The summer would be a better time to visit anyway. I'd tell him about my writing projects then—something I rarely shared with anyone. There was time. Lots of time.

Summer never came...death did. My Dad!

Gisele Fontaine Kermer, RN, author of "Denial", works as a lab demonstrator in the Nursing Diploma Program at Langara College in Vancouver. From time to time she also teaches Basic Cardiac Life Support at the Royal Columbian Hospital/Douglas College Education Center. Writing, she says, is her way of sorting out her thoughts; "Denial" was written following the death of her father last Spring. "I wrote it for him," Gisele comments, "but perhaps other nurses can identify with it."



# A developing framework for oncology nursing

*Diana Law and Barbara Price*

Care for cancer patients has changed in many ways over the past five to 10 years. Some of these changes are the direct result of rapidly changing methods of treatment; others are the result of changing philosophies and administration of care. Specialization in "oncology" has also become a reality for both medicine and nursing and, particularly in the larger medical centers, this directly affects the organization of patient services. Acute care oncology units, outpatient cancer clinics, palliative care units or hospices (with or without home care programs), community nursing programs for home care...all of these services are active or developing at the present time in various parts of the country.

As nurses working with cancer patients in this time of rapid change, we are concerned with the quality of patient services and the role of nursing in these services. We want to share with you our philosophy and objectives for "oncology" nursing, and outline our thoughts on administration of an acute care oncology unit. We hope that putting our thoughts on paper will help you if you are in a similar situation; we hope too that it will facilitate discussion of some of the larger issues involved, those we cannot deal with in this paper, for example, patient advocacy, pros and cons of specialization, continuity of patient care between services, postgraduate programs for oncology nursing, etc.

**P**hilosophy of oncology nursing  
We list here the major beliefs in our philosophy of oncology nursing so that you may consider them in devising your own. We believe:

- cancer is increasingly a chronic illness with intermittent acute episodes, rather than an acute illness with early death
- nursing care of patients diagnosed with cancer is a distinct nursing specialty
- oncology nursing is an integral part of a multidisciplinary, coordinated approach to patient care
- the main focus of care should always be on the optimal functioning of the patient and family at any stage of the illness
- the nurse should act as the patient advocate when necessary
- the patient has a right to know the disease, prognosis and plan of treatment and should be included in the decision-making
- it is important to do nursing research and to assist and support our colleagues in their research efforts.

Our objectives are:

- to deliver comprehensive quality health care to each patient and family by establishing policies, procedures and standards of care
- to develop an awareness and understanding of the patient with cancer and to realize the impact of the illness on the family
- to provide patient and family education as a consistent part of care
- to provide for outpatient care so the patient can remain an active family member

- to monitor standards of professional performance through constant evaluation and to provide for staff counseling as necessary
- to provide and encourage an atmosphere of learning and staff development through orientation and continuing education programs
- to support the nursing profession by exemplifying quality care to nursing students
- to maintain relationships with other departments
- to provide job descriptions which define the role of oncology nursing and clarify functions of each level of nursing practice
- to participate in research to improve patient care.

We believe it is important to have our objectives clearly defined and adopted by all nursing staff. These objectives evolved from daily experiences on the unit, especially those surrounding difficult issues such as cure vs. care, staff and personal conflicts, family participation, etc. We use every opportunity that arises to further develop our goals: sharing experiences, concerns and ideas in unit meetings, at coffee break, and during incidental problem solving situations. We attempt to realize our objectives on a daily basis through head nurse - primary nurse rounds and conferences with other team members (social worker, dietician, etc.) as necessary to plan patient care.

## Staffing

Patients on an acute care oncology care unit are generally in the midst of aggressive treatment for their malignancy. Although the available treatments hold out hope of cure or longer remission periods for many patients, these new protocols often place the patient in a position of physical and emotional jeopardy. Toxic side effects of therapy include alopecia, nausea, vomiting, neurotoxicity,



immunosuppression, stomatitis, bone marrow depression, carditoxicity, hemorrhagic cystitis and renal and/or liver failure. From admission to discharge the patient will require intensive nursing observation and intervention and this is a major factor in the staffing requirements affecting both quantity and quality. We have based our personnel requirements (see Figure one) on a 38-bed-unit.

There are few formally trained oncology nurses due to the lack of training programs in Canada; the nurse seeking such training must go to either the United States or Britain. We have learned, however, that training and experience need not be top priority considerations in the hiring of staff; the important qualifications are much broader in scope. Many explicit questions should be asked by nursing management when considering the "type" of nurse qualified to work on an oncology unit:

*What is it about this kind of nursing position that made you apply?*

*What do you feel you would need to know before you could do this job?*

*What are some of your goals for this job?*

*How will you accomplish these goals?*

*How would you describe your leadership style? Why?*

*What about yourself could be improved or strengthened?*

*What do you enjoy most about nursing?*

*What kind of people do you work best with?*

The initial interview is critical in selection of staff for an oncology unit. The head nurse must have a large part in the decision to hire; we consider this a joint responsibility of the coordinator and head nurse.

There should be a pool of permanent part time staff for this unit that allows for staff replacements by experienced nurses during sick leave, vacations, etc.

## Shifts

The question of the numbers of hours nurses should work in a shift (eight or 12) on an oncology unit is always an issue of debate. Some concerns that have been raised in other institutions are:

- Can nurses endure 12 hours of active duty considering the intensity of nursing required or does having several days off in a row provide a needed break?

- Does the 12 hour shift provide greater continuity of care? per day? per week?

- Will the 12 hour shift be routine for full and part time staff? If not, what problems will this create?

## Delivery of nursing service

Discussion of the general organization must be considered in two ways:

- the functioning of the multi-disciplinary care team and
- the delivery of nursing care to patients.

The traditional hierarchy no

longer provides an efficient system for coordinating care because of increasing technology, more specialized professionals and the need for rapid, complex decision making. A "matrix organization" system is a better approach for functioning of a multi-disciplinary care team. This form of organization embraces both hierarchical (vertical) and lateral (horizontal) communication and coordination. Two methods of facilitating communication and enhancing the reality of matrix organization are: (1) to physically design or arrange the unit so that staff are more likely to mix and exchange ideas and concerns about patient care and (2) to have rounds for all staff that are organized and timed so that as many as possible can attend. We want nurses to participate more in decision making and to enhance their education; the lateral communication within the matrix organizational form offers more opportunities for individual initiative and participation. The quality and effectiveness of such organization naturally depends on moving these concepts from discussion to use.

For delivery of nursing care to patients we advocate primary nursing rather than team nursing. Because of their illness, patients will be involved with nurses, doctors and other health professionals, their relationships with family and friends will be affected and many personal changes will occur. A system like primary nursing with a one-to-one, nurse-patient relationship

## Acute Care Oncology Unit: - Projected Nursing Complement and Mix

1 Research Nurse - 1 HN - 1 Clinical Nurse Specialist

33 Beds

Extra Care Unit - 4 Beds

1 AHN

35.5 SN

3 RNA

2 U.C.

1.9 Unit Aide

This will yield 6.5 nursing hours per patient per 24 hours.

1 AHN

15.8 SN

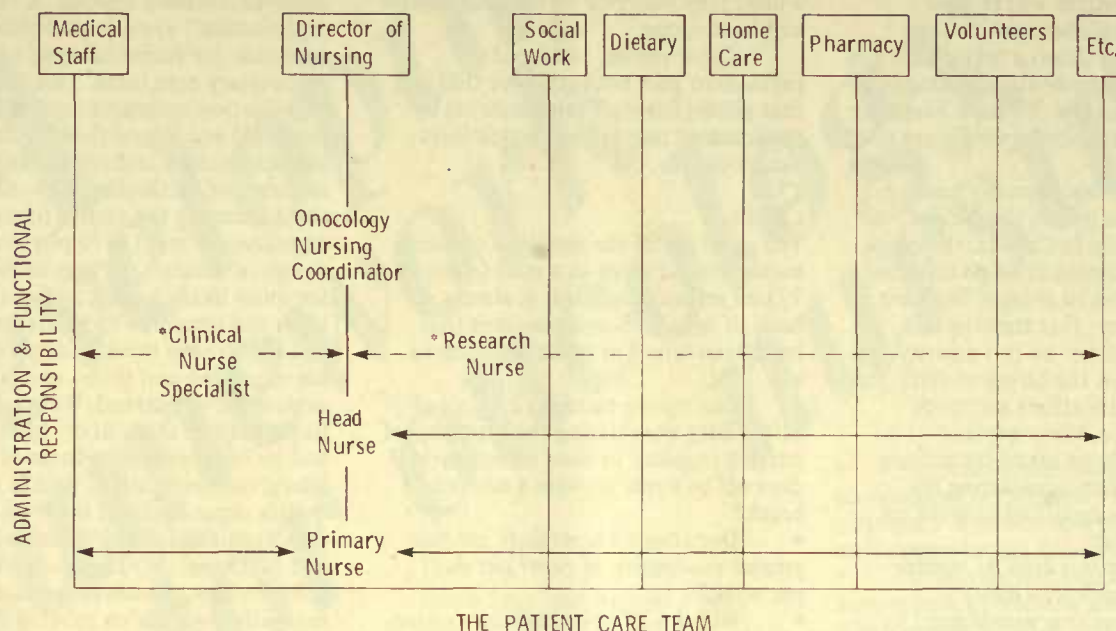
1 U.C.

This will yield 16 nursing hours per patient per 24 hours.

Fig. 1



## Matrix Organization



\* The positions of clinical nurse specialist and research nurse may evolve as the global needs of our oncology unit become more clearly defined and operational.

Fig. 2

is necessary so the nurse can act as a mediator and facilitator.

The central principles of primary nursing are:

- 24 hour-a-day accountability for the nurse realized through written and verbal planning and communication
- a case method of assignment in which care planner is care giver; the nurse gives total patient care: initial assessment, planning, implementing and evaluating that care.

We are now in our third year of "modified" primary nursing and we continue to strive towards full implementation of the concept. The process of change from team to primary nursing has brought considerable anxiety, frustration, joy and satisfaction. The two greatest hurdles have been the psychological aspects of change and the mechanics of patient staff assignments; we have tried to meet these challenges through unit meetings and combined, planning efforts.

In comparing team and primary nursing after our three year experience we have concluded that primary nursing:

- offers more holistic, patient centered care (as opposed to fragmented task oriented care)
- makes communication less complex because the primary nurse is central and a direct patient link

- increases autonomous functioning of the nurse, thus furthering self-development
- encourages constant learning
- makes the staff nurse role less managerial and more clinically oriented
- allows the matching of patient-nurse needs and abilities.

### Staff development

Ours is a "four point" program for staff development that covers the following areas:

- *orientation program*
- *continuing education program*
- *staff exchange program*
- *staff stress-reduction program.*

#### Orientation program

Oncology nurses must become knowledgeable in the fields of hematology, infectious disease, immunology, radiation therapy, chemotherapy of neoplastic disease and psychology. Developing expertise in physical and emotional assessment of patients with cancer is another required skill. An adequate orientation program must offer the new staff nurse both information and time to gain practical experience. Methods for achieving a good program are many and varied, but it is essential to have objectives clearly defined first. Staff nurses should be involved in the development of the program.

Suggestions for specific program content include:

I General information about the organization of the hospital and unit; the philosophy and objectives of oncology nursing; clinical information: pathology of neoplasms, detection and treatment procedures, pain control, theories of chronic illness and rehabilitation, community resources, death and dying, etc.

II Practical experience in new technical skills, e.g. starting IV's, preparation and administration of antineoplastic drugs, etc.; physical and emotional assessment of patients; experience in nursing patients with specific symptoms of cancer or suffering side effects of therapy; and participating in rounds, patient care conferences, etc.

At the end of the orientation period the head nurse and new employees should meet for an evaluation session. This should be a time to exchange perceptions and to determine plans for further development.

#### Continuing education

Some plan for continuing education for staff is an administrative must; one very good reason for this is the continual change in medical treatment modalities which directly affects nursing care. It will be necessary then to consider this in planning staff schedules; if education is



to be effective it must become a part of the philosophy and functioning of the unit. Whether programs are formal or informal, conducted on the unit or off, organized by hospital inservice or unit personnel, is not the significant factor: any arrangement that suits the institution and works for staff is a positive option. The crucial factor is administrative and staff commitment to an educational program as one method of improving patient care.

#### Staff exchange program

Another method for staff development we have found invaluable is to have an exchange of staff with an outpatient treatment clinic. This exchange of staff between different types of treatment facilities should help meet the following objectives:

- to provide oncology nurses with the chance to appreciate the total course of illness and treatment – initial diagnosis, treatment on an in or outpatient basis, partial or complete remissions, and/or terminal care
- to help nurses working in palliative care maintain a positive attitude toward treatment of malignant disease
- to help foster a realistic attitude toward malignant disease so that appropriate recognition and treatment will ensue if the patient reaches a terminal phase.

We hope to designate an "extra care" unit within our larger unit, using a core of specially trained nurses. Should this become a reality, we will develop a schedule to rotate all nursing staff through this area to broaden their experience.

#### Stress-reduction program

The stress of continually nursing patients with cancer must be taken into administrative consideration. As with the educational areas probably the most important thing is to be serious about this need and to have some action plan. Group sessions might be useful for this purpose; other hospital staff could act as resource persons for these groups, for example, other nurses, chaplains, social workers, etc. Staff could develop methods of helping each other or a list of staff able and willing to offer individual help could be made available; the variety of possibilities is great. Perhaps the arrangements made for helping staff might also be a useful adjunct in helping patients and their families.

#### Conclusion

We continue to work towards our goals; some of our present activities are:

- working on a design for the unit that will help us meet our objectives
- completing an outline for a

certification course for oncology nursing

- having a pastoral care resident work with patients, families and staff to offer support and leadership
- exploring concepts for future use in a patient-family education program.

It is not easy to plan and implement any new program; that's why we have chosen to share our ideas and experiences with you. ♦

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\*Not verified

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Diana C. Law, RN, BScN, is a graduate of the Toronto General Hospital School of Nursing and has completed a postgraduate course in psychiatric nursing. She is working at the Foothills Hospital in Calgary as medical nursing coordinator. She is also the author of an article in the February issue of *The Canadian Nurse* on chemotherapy.

Barbara J. Price, RN, is a graduate of St. Michael's School of Nursing in Lethbridge, Alberta and has completed a postgraduate course in pediatric oncology. She has held various positions at the Foothills Hospital in Calgary where she is presently working as an instructor. Her article on caring for the child with cancer appeared in the December, 1979 issue of *The Canadian Nurse*.

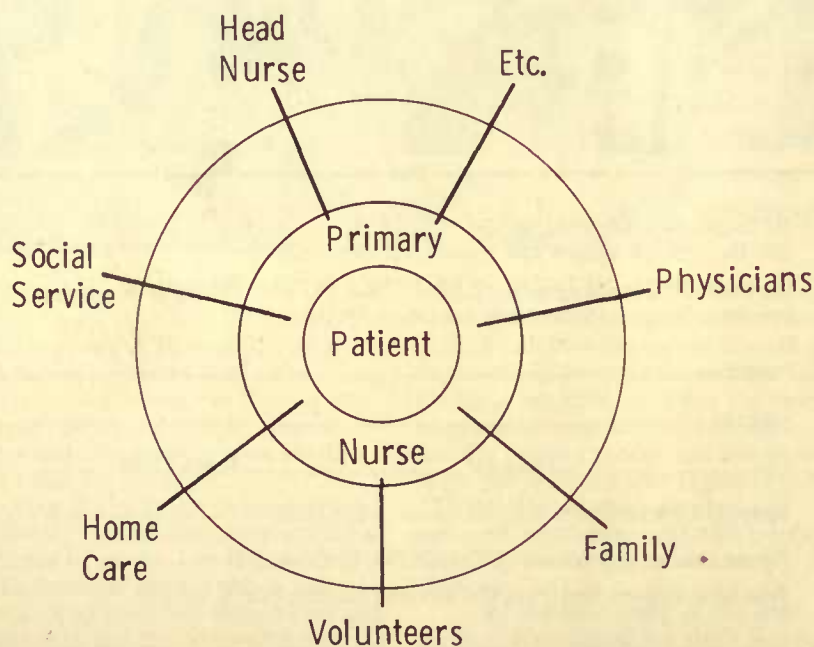


Fig. 3



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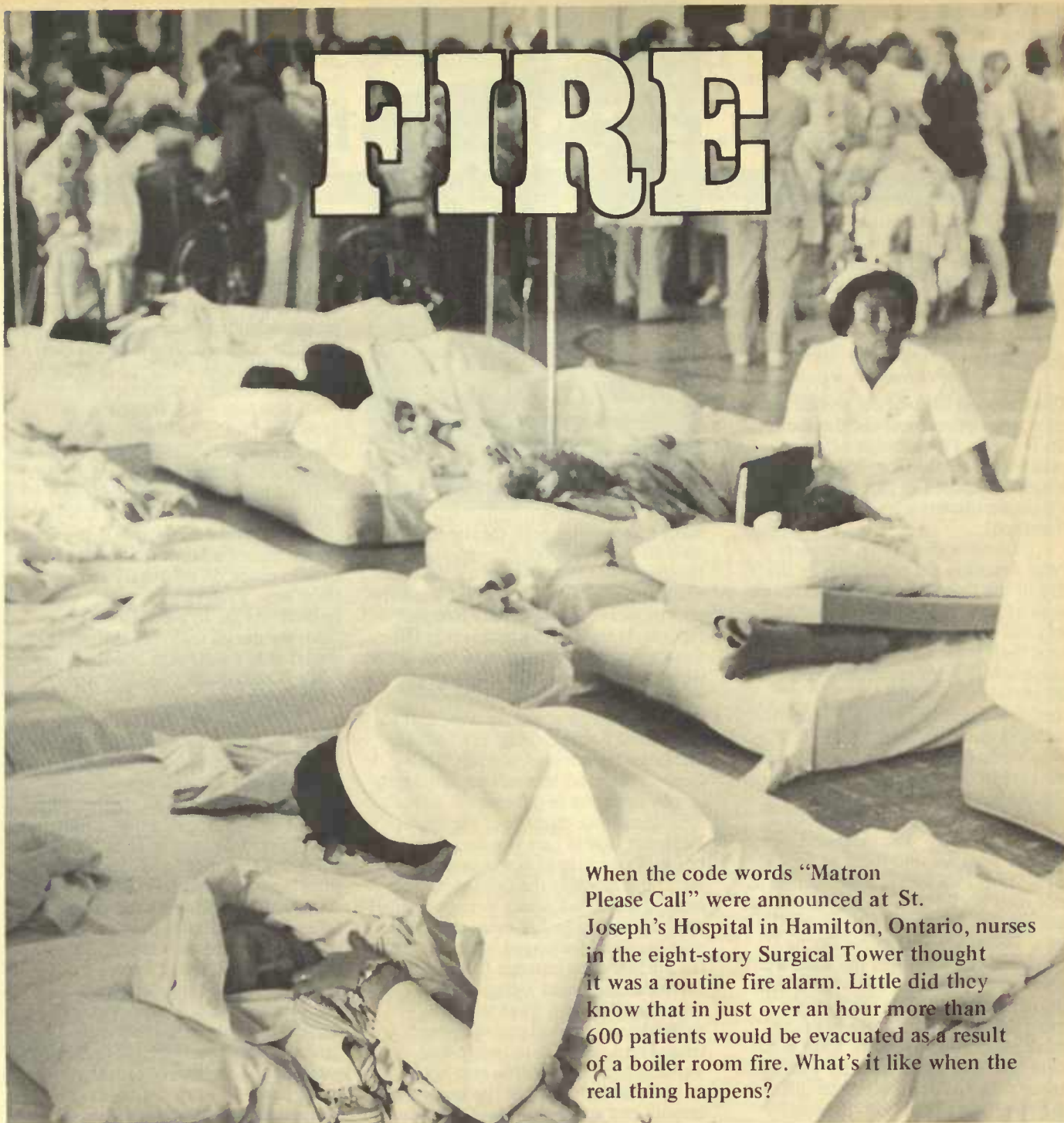
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# FIRE



When the code words "Matron Please Call" were announced at St. Joseph's Hospital in Hamilton, Ontario, nurses in the eight-story Surgical Tower thought it was a routine fire alarm. Little did they know that in just over an hour more than 600 patients would be evacuated as a result of a boiler room fire. What's it like when the real thing happens?

*Cathy Squires*

On the morning of Thursday, May 1, 1980, general medicine staff nurse, Georgia Schmiedeberg was clearing up the breakfast trays of her 16 chronic care patients when thick, acrid smoke poured into the corridors.

Four floors up, cardio respiratory head nurse, Thelma Blair, also noticed a faint smell of smoke. Convinced it was coming from the garbage shoot, she ordered all patients into their rooms and the nurses to seal the doors with wet towels but, seconds later, the eye-stinging smoke began spewing out of the vents in each room. She quickly

had all patients moved out into the hall.

Meanwhile in orthopedics, head nurse Sarah Fleming sensed trouble and began handing out masks and wet face cloths to her patients. When the order to evacuate came at 9:50 a.m., she quickly began a production line to have them moved down four flights of stairs. The traction on one patient was removed; another patient with a spinal fusion had to be loaded onto a stretcher.

By the time many of the staff at St. Joseph's realized the alarm was for real, evacuation procedures were well under way. Production lines to move bedridden patients down the two

remaining stairwells had been formed automatically. Housekeepers, volunteers and maintenance men carried patients out into the parking lot while those who were ambulatory linked arms and made their own way outside.

Nurses on their day off suddenly appeared on the scene — some clad in jeans. Those without their pins were not allowed to enter the building but instead acted as taxis, driving patients home.

Sue Spence, a general medicine staff nurse, had just arrived home from working the evening shift when she heard the news. Reaching for her uniform, she raced out the door and ran



the two blocks back to the hospital. Weaving her way through the crowd, she arrived at the main entrance and immediately pitched in — no questions asked.

By 10:30 a.m. the parking lot at St. Joseph's was jammed with patients on stretchers, wheelchairs and mattresses. All were bundled in blankets and many were accompanied by nurses holding IV bottles. Within moments 38 ambulances, 8 city buses, 11 fire trucks and even a postal truck arrived on the scene to transport them to waiting hospitals.

## Evacuation

The electrical fire was the second test of emergency procedures for the staff at St. Joseph's. Five months before, patients evacuated from Mississauga hospitals exposed to chlorine gas during a train derailment were brought to Hamilton.

Director of nursing, Margaret Peart describes the procedure on the day of the fire as quiet and without any signs of panic. "I'm really proud of the way the nurses acted," she says. "They kept their cool and used good judgement." Peart says the nurses put themselves at personal risk and conducted themselves in a professional, caring manner.

Pediatrics on the third floor was the first to be evacuated. Staff nurse Sheila Maggio recollects that the children were carried out on a one-to-one basis. "The mothers listened and did what we told them to do," she says. "But if we hadn't been there, I'm sure they would have taken their babies and run."

Pediatrics head nurse Donna Danecker never thought the ward would have to be evacuated, but when a little girl ran past her saying "she wasn't going to stay to burn," she began to think about the possibility. One of her main concerns was a teenager with brain damage. "I knew she would be difficult to move," says Danecker. Eventually the teenager was put on a stretcher and brought out along with the rest of the patients. Firemen smashed more than a dozen windows in the pediatric ward.

The only people left in the building after the evacuation were the surgical teams for two operations in progress. Eight operations had been scheduled that morning but only two had begun. OR head nurse Phyllis Morelli remembers that nurses in the operating theatres felt "very closed in". "They all had an uneasy feeling about what was going on outside," she says. "They didn't know how bad the fire actually was."

Although the OR nurses stuffed wet towels around the doors, smoke



wasn't a problem: each theatre has its own air supply. When the operations finished more than two hours after the evacuation had begun, the patients were sent to McMaster University Hospital to recover. Morelli says the nurses in OR were prepared if necessary to pack the wounds with sterile dressings and get out quickly.

St. Joseph's patients were sent to other local hospitals such as Chedoke, McMaster, Henderson and Hamilton General Hospital; several nearby nursing homes also took in patients.

Associate director of nursing at McMaster, Sonia Franklin says the hospital's disaster plan was put into effect the moment the call for help came. Two closed wards were opened up immediately and as many patients as possible were discharged to make way for the incoming patients from St. Joseph's. The busier things got, the smoother they ran; more than 60 pediatric and surgical patients were triaged and settled into the 35-bed wards at McMaster within two hours.

Franklin describes the transfer as smooth and commendable. "Everyone

rose to the initial disaster," she says. "People came in on their day off and heads of departments were cleaning beds." After awhile, however, Franklin says, the continual pace began to tell on her staff. "Everyone's adrenalin was up for the first day but eventually my nurses felt the strain."

## Aftermath

Although nurses from St. Jo's were used to staff the new wards at McMaster, the fact that there was one less hospital operating in town created temporary pressures on the remaining facilities. For example, while St. Joseph's was closed, Franklin noticed a definite increase in labor and delivery patients.

She realized that there were problems for the nurses from St. Joseph's as well. "Little things made the adjustment difficult," she said. "Each hospital has its own way of doing things — like charting."

Margaret Peart agrees that minor details caused a bit of friction. "I went over to check on my nurses and none of them were wearing their caps," she smiled. "At St. Jo's we always wear caps. My nurses told me McMaster nurses didn't wear caps and that they'd feel too out of place wearing them. What could I do?"

Although the nurses involved in the evacuation came through with flying colors, their director of nursing worries there are still some emotional scars they'll have to deal with. Orthopedics nurse Fleming, for example, admits she shook for more than an hour when she got home that night and didn't sleep for three days thinking how lucky they were. The lounge set up for the nurses following the disaster provided a place to talk and come to terms with their initial feelings. "But it's going to be a long while before these nurses feel comfortable again," Peart comments. On one thing though, every nurse agrees: the episode brought them closer together and reassured them that they could deal with such a situation if it ever happened again. ♡





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—Pat Zehr, Chesley, Ontario.

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what has been done and prevents  
unnecessary discomfort for the patient.  
—Kathy Trip, RN, IV Team, Toronto  
East General and Orthopedic Hospital

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At the Stanton Yellowknife Hospital  
the pediatric staff have designed a  
"Travelling Trunk" program to orient  
schoolchildren to the hospital. Many  
ideas came from the successful  
"travelling suitcase" program of the  
child life department, Isaac Walton  
Killam Hospital in Halifax. Our program  
is meant for children in the Indian  
settlements near Yellowknife and the  
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negative comment made was on the  
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container is not childproof it should not  
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#### Our "well-being"

The April issue was undoubtedly one of the best that I have ever enjoyed. Having worked in "prevention" (from the dental health end) for the past seven years I am particularly pleased to see the continuing emergence of the nurse as a key person in optimal health promotion.

Being fit and well is the best gift we could ever share with our fellow humans; and as driving forces in the health field it is very much our responsibility to do whatever we can.  
—Linda Anaka, RN, Revelstoke, B.C.

#### The voice of the student

Nursing students from the University of Saskatchewan were among those who presented briefs to Health Services Review '79. As members of this group we would like to highlight some of our recommendations, particularly those related to education, research and the expanded role of the nursing component in the health care system: nurses are working to define new roles; improvements in educational programs have led to the development of nursing expertise and the legitimate right to practice as autonomous professionals.

We see nursing research as a necessary framework for the development of new concepts in health care, as well as the improvement of

present clinical skills. We recognize the inadequacy of funds for nursing research as a problem needing attention. One solution may be in the realm of research centers, and the provision of ongoing funding for research studies.

Findings presented to the Kellogg National Seminar (December, 1978) indicate that only 51 of Canada's 180,000 nurses are prepared at the doctoral level and only six of these have doctoral degrees in nursing. Canadian nurses, including educators, are in dire need of doctoral programs in nursing. We recommend, therefore, that these programs be established in Canada's four main regions and that masters degree programs in nursing be established in each Canadian province.

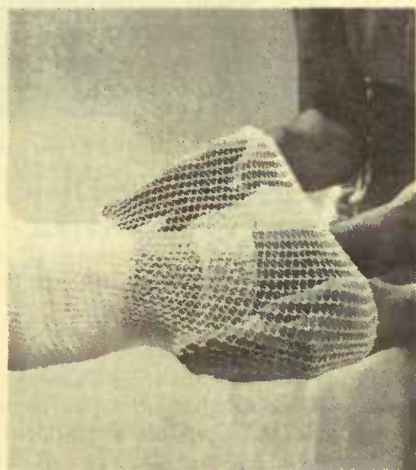
The reluctance of health care professionals to see collaboration as a means of filling gaps in the health care system has resulted in increased health costs and dissatisfaction among consumers. The effective utilization of nursing professionals in expanded roles can improve the accessibility and quality of health care delivered to the public. A mutual recognition of professional capabilities would enhance joint practice in which the overlap of services could virtually be eliminated.

We feel that serious consideration and implementation of the above will ultimately have definite positive effects on our future health care system.

—Heather Conway, Meagan Griffin,  
Pam Reilly, College of Nursing,  
University of Saskatchewan. ♣

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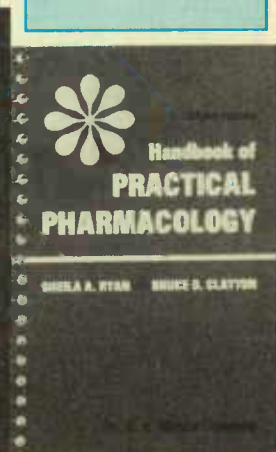
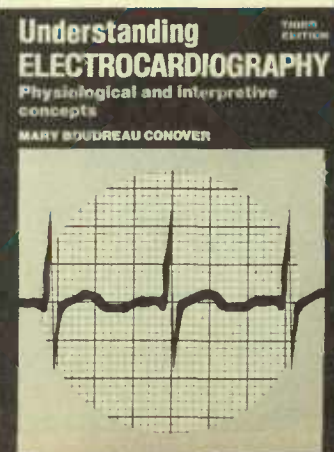
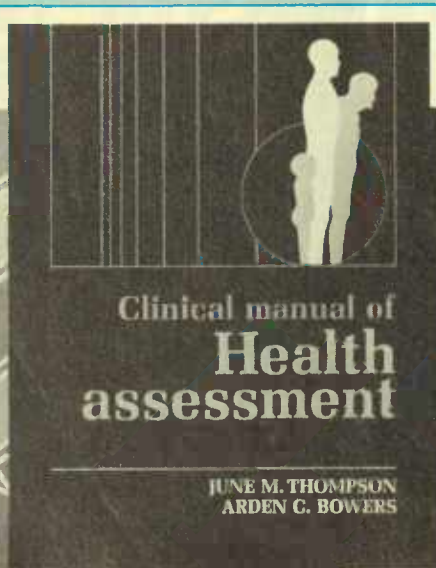
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Respiratory Ambulatory Care Program. Saint Joseph's Health Centre is an acute and chronic care hospital servicing the community health needs of West Toronto. We are seeking a Registered Nurse for an expanding hospital based home visitation programme. A challenging and rewarding position focusing on patients with chronic lung disease. Candidates must be currently registered in Ontario, preferably experienced in Respiratory Nursing and Adult Education, possess a car and a valid driving license. Salary commensurate with experience together with excellent employee benefits. Apply with resume in confidence to: Nellie Iglar, Personnel Department, St. Joseph's Health Centre, 30 The Queensway, Toronto, Ontario M6R 1B5 (416) 534-9531, Ext. 543.

## Saskatchewan

General Duty R.N.'s required immediately for a 20 bed Rural Hospital located near provincial park. New hospital, modern equipment, all areas of nursing done, surgery, obstetrics, pediatrics, emergency and general medicine. Modern community, bus services, paved streets, etc. Wages and fringe benefits as per 1980 S.U.N. provincial agreement. For further information please contact: Administrator, Porcupine-Carragana Union Hospital, Box 70, Porcupine Plain, Saskatchewan S0E 1H0. Phone (Bus) 278-2233 or 278-2211 (Res) 278-2450.

## United States

RN'S—Our Florida hospitals need you! Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. No Fees! Call or write: Medical Recruiters of America, 3421 West Cypress St., Tampa, Florida 33607 (813) 872-0202.

## Miscellaneous

Adventure Holidays: Camping Safaris, Overland Expeditions and Fun Experiences. We offer trips from one week to 3 months in: Canada, USA, Europe, Africa, Asia, South and Central America, Australia, New Zealand and the Caribbean. For FREE catalogue, contact your travel agent, or apply to: Goway Travel, 53 Yonge St., Suite 101, Toronto, Ontario M5E 1J3. Phone: 416-863-0799. Telex: 06-219621.

## United States

RN/Staff & Management Positions—Kaiser-Permanente, the country's largest Health Maintenance Organization, currently has excellent opportunities available in our 583-bed Los Angeles Medical Center. Located 7 miles from downtown Los Angeles, close to many of California's finest Universities, this teaching hospital offers RN's a unique chance to further their careers in such areas as: OR, Med/Surg, Maternal Child Health & Critical Care. Management positions are also available. Kaiser offers an attractive array of fringe benefits including relocation assistance, full medical, dental & health coverage, continuing education advanced training available in the Nurse Practitioner & CRNA Programs, individualized orientation, tuition reimbursement, and no rotating shifts. New graduates are always welcome and encouraged to inquire. For more information, please write or call collect: Ann Marcus, RN, Kaiser Hospital/Sunset, 4867 Sunset Blvd., L.A., California 90027. (213) 667-8374.

## United States

California—Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, Ext. 1680.

Total patient care with all licensed personnel is our goal! Staff RNs currently interviewing for part-time and full-time positions. Full service, except psych, progressive 156-bed accredited acute general hospital. Located within 60 minutes from LA, the ocean, mtns., and the desert. Orientation and staff development programs. CEUs provider number. Parkview Community Hospital, 3865 Jackson Street, Riverside, California 92503. Write or call collect 714-688-2211 Extension 217. Betty Van Aernam, Director of Nursing.

# NURSING OPPORTUNITIES CALGARY, ALBERTA

As Calgary's population increases, our hospitals are expanding to meet the growing demand for high quality medical care. We require skilled Nurses who are interested in the challenge and excitement of working in a progressive environment and earning a better than average salary.

The recent nursing settlement has resulted in significantly revised salaries for Alberta Registered Nurses.

Present salary range is from \$1,455.00 to \$1,717.00 per month.

October 1, 1980 range will be \$1,581.00 to \$1,867.00 per month. March 1, 1981 range will be \$1,701.00 to \$1,987.00 per month.

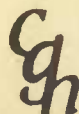
In addition we offer excellent benefit packages which will include a dental plan by December 1, 1980. The Calgary General, Colonel Belcher, Foothills, Holy Cross and Rockyview Hospitals have Staff Nurse positions available in most clinical areas.

For further information or applications, you may contact:

**Calgary General**  
841 Centre Avenue E.  
Calgary, Alberta  
T2E 0A1  
Ph.: (403) 261-3800

**Foothills**  
1403 - 29 Street N.W.  
Calgary, Alberta  
T2N 2T9  
Ph.: (403) 270-1411

**District #93**  
940 - 8 Avenue S.W.  
Calgary, Alberta  
T2P 1H8  
Ph.: (403) 264-9880





## R.N.'s

Would you like to nurse in:

California, with Beverly Hospital, a 212 bed acute care hospital in Montebello just minutes from Los Angeles.

Ohio, with the Jewish Hospital of Cincinnati, a 604 bed teaching hospital.

Florida, with American Hospital, growing to 400 beds in a very livable part of Miami.

All of our client hospitals encourage pre-employment visits by paying all or part of visit costs. Our services are free to nurses.

Wherever you would like to move, we can help you get there.

Wood, Watson Professional Search  
12 Sheppard Street  
Toronto, Ontario  
M5H 3A1  
Phone: (416) 261-6825

### **Before accepting any position in the U.S.A. PLEASE CALL US COLLECT**

**We Can Offer You:**

- A) Selection of hospitals throughout the U.S.A.
- B) Extensive information regarding Hospital— Area. Cost of Living, etc.
- C) Complete Licensure and Visa Service

**Our Services to you are at  
absolutely no fee to you.**

### **WINDSOR NURSE PLACEMENT SERVICE**

P.O. Box 1133 Great Neck, N.Y. 11023

**(516) 487-2818**

Our 23rd Year of World Wide Service

## R.N.'s

**Come to Texas**

- 244 Bed Regional Medical Center
- Located 75 miles north of Dallas on the banks of Lake Texoma (12th largest lake in the U.S.)
- Progressive Nursing Administration
- Professional growth opportunities
- Excellent salary and benefits program
- Openings in ICU, Emergency, Psychiatry, Renal Dialysis, and other speciality areas

**Contact:**

Bonita Palmer, R.N.  
Director of Nursing  
Texoma Medical Center  
P.O. Box 890  
Denison, Texas, USA 75020

# **WHY WOULD A CANADIAN NURSE SELECT UCLA?**

## **ASK ONE!**

UCLA Center for the Health Sciences will be conducting interviews for RNs in the following areas:  
**Halifax, Ottawa, Toronto and Sault Ste. Marie.**

Two of our outstanding Head Nurses (who incidentally are Canadian) will be interviewing registered nurses and making job offers in the following areas: Peds & Peds ICU, General Medicine, General Surgery, Intensive Care, Neuro Surg., OR, Maternal Child, Female Surg., Psych. We offer many other opportunities, watch your local newspapers for dates and locations.

If you're not located in any of these areas, call us collect, and we'll attempt to meet with you if at all possible. Call our Nurse Recruiting Office at **(213) 825-8141**. We're an equal opportunity employer.

# **UCLA Medical Center**



# HOSPITAL CORPORATION INTERNATIONAL

## Interested in a Challenge?

### Try International Nursing - In Saudi Arabia

If you are looking for a change, a chance to travel, some hard work and adventurous living, then you might consider international nursing. You will have not only the opportunity to give — to share your nursing expertise — but the opportunity to receive as well — to learn by living in a completely different culture. Truly, a chance for personal and professional growth.

Available positions include both administrative and staff level nursing. Requirements depend on the position — at staff level a minimum 2-3 years current experience in an acute care hospital or clinic setting. Current R.N. license in one of the Provinces. Single status contracts are offered for 18 or 24 month periods.

Attractive salaries with excellent benefits including air transportation, furnished lodging, generous vacation, bonus pay and bonus leave.

Interested in this once in a lifetime opportunity? For more details, please send professional resume to:

Kathleen Langan  
Hospital Corporation International, Ltd.  
Two Robert Speck Parkway, Ste. 750  
Mississauga, Ontario L4Z 1H8

An Equal Opportunity Employer

## Registered Nurses

The Perfect Opportunity Could Be  
Right Around The Corner

How can you be certain that the opportunity you see to-day is the best one for you?

We know where the best jobs are, how much they pay, and where you'll fit in. R.R.N. can give you more than just a job — we can help you build a satisfying career.

The truth is, you can't, without the guidance of job-market professionals who know the nursing business as well as the placement business. That's why, before you sign on that dotted line to-day, you should check with Recruiting Registered Nurses Inc. We're the Canadian Medical Placement Specialists throughout the United States.

R.R.N. has immediate positions available in:

California — Ohio — Pennsylvania — Michigan

Don't wait!!!! Call or write immediately for further information.

"No Fee To Applicants"

RECRUITING REGISTERED NURSES INC.



1200 Lawrence Avenue East  
Suite 301, Don Mills  
Ontario M3A 1C1  
Telephone: (416) 449-5883

## Interested In Paediatric Nursing ? Toronto, Canada

The Hospital For Sick Children invites applications for all units from experienced nurses interested in working in a paediatric tertiary care setting.

We are a fully accredited 700 bed paediatric teaching hospital affiliated with the University of Toronto located in the thriving environment of downtown TORONTO. A thorough orientation and a variety of continuing education programs is provided. The majority of units operate on a 12 hour shift basis, which normally allows every other weekend off. A comprehensive employee benefit package, including a Dental Plan is offered.

Our philosophy is Family Centred Care.

### Qualifications:

- Current registration with the Ontario College of Nurses or eligibility for registration.
- Recent related experience in an active treatment setting preferred.
- Paediatric experience would be considered a definite asset.

Applicants are invited to contact:



Dorothy Franchi,  
Personnel Co-ordinator,  
The Hospital for Sick Children,  
555 University Avenue,  
Toronto, Ontario, Canada M5G 1X8,  
(416) 597-1500 ext. 1675.

## The Hospital for Sick Children





Immediate openings for qualified RN's on all shifts, full time, part time. 203 bed JCAH accredited acute care hospital, adjacent to Oregon Institute of Technology, offering a 2 + 2 AD/BSN program. We are located in Southern Oregon. Excellent year 'round outdoor activities. Family oriented community. Excellent working conditions and benefits. Competitive salary with opportunity for advancement. Contact Personnel Department, MERLE WEST MEDICAL CENTER, 2865 Daggett St., Klamath Falls, OR 97601, or call COLLECT (503) 882-6311, Ext. 131. We are an equal opportunity employer.



## Registered Nurses

300 bed Accredited general hospital in Vancouver requires full-time, part-time and casual R.N.s for general duty and ICU nursing. Candidates should be eligible for registration in B.C. Recent nursing experience preferred. ICU candidates must have previous ICU experience.

Please apply to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C.  
V5T 3N4



## Royal Jubilee Hospital Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

Victoria Hospital Corporation  
London, Ontario



## Registered Nurse Positions

Available Early 1981

Full-Time/Part-Time

Medical - Surgical

Obstetrics - Gynecology

Paediatrics

Critical Care

This large teaching hospital, affiliated with The University of Western Ontario, presently undergoing complete redevelopment

Offers:

- Good fringe benefits
- Active orientation and educational programmes
- 8 hour and 12 hour rotating tours
- Fitness programme
- Employee Health Service
- Recreational facilities

For information and application contact:

Employment Division  
Human Resources Department  
Victoria Hospital Corporation  
375 South Street  
London, Ontario  
N6A 4G5

## Director of Nursing

St. Joseph's General Hospital, Comox, B.C. invites applications for the position of Director of Nursing.

St. Joseph's General Hospital is a fully accredited 190 bed hospital (45 E.C.U.) expanding to 220 beds (75 E.C.U.) in 1981.

The Director of Nursing will report to the Executive Director and will be responsible for the administrative and professional activities of the Nursing Department as well as the quality assurance of nursing practice throughout the hospital.

The applicant must have a BScN (minimum), a recognized course in health administration and be eligible for B.C. registration.

A minimum of three years in a senior management position is required.

Send complete resume to:

Sister Christine  
St. Joseph's General Hospital  
2137 Comox Avenue  
Comox, British Columbia  
V9N 4B1

## The Izaak Walton Killam Hospital For Children

### Staff Nurses

The I.W.K. Hospital for Children has vacancies for Staff Nurses on our Intensive Care Unit and Neo-Natal Unit. Must be a graduate from an accredited School of Nursing and be eligible for registration in Nova Scotia. Previous pediatric experience would be an asset.

Inquiries and applications should be directed to:

Karen Lyle  
Personnel Officer  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
B3J 3G9

## Registered Nurses

Registered Nurses are required for an 87 bed accredited Hospital in Northern Ontario.

Applicants must be eligible for Registration with the College of Nurses of Ontario.

Bilingualism is an asset.

Salary and Fringe Benefits in accordance with O.N.A. Contract.

Temporary residence accommodation is available.

Please apply in writing to:

Director of Nursing  
Sensenbrenner Hospital  
10 Drury Street  
Kapuskasing, Ontario  
P5N 1K9

## Assistant Supervisor of Nurses Peace River Health Unit

An Assistant Supervisor is required in the main office of the Health Unit. Peace River is located 500 km. northwest of Edmonton.

### Duties:

Assist in planning, organizing, coordinating and evaluating community health nursing programs. A limited caseload will be assigned.

### Qualifications:

B.Sc. in Nursing preferable.  
Community Health Nursing experience essential.

### Salary:

Negotiable and dependent upon qualifications and experience.

Please apply to:

Supervisor of Nurses  
Peace River Health Unit No. 21  
P.O. Box 69  
Peace River, Alberta  
T0H 2X0







**MIDWIFERY TUTOR — NIGERIA**  
**NURSING INSTRUCTORS — COLOMBIA**  
**& PAPUA NEW GUINEA**  
**PROFESSOR OF NURSING — PERU**  
**PUBLIC HEALTH NURSES — WEST**  
**AFRICA & PAPUA NEW GUINEA**

CUSO, Canada's largest non-government international development agency, is seeking qualified and experienced nurses for the above positions.

**Qualifications:** Positions require appropriate degree (diploma for midwifery position) plus relevant experience.

**Contract:** Two years.

**Salary:** At local rates with fringe benefits.

For more information, write:

CUSO Health D1 Program  
 151 Slater Street  
 Ottawa, Ontario  
 K1P 5H5

### Nursing Coordinator

Nursing Coordinator required to assume leadership role in an O.R./P.A.R. and expanding Emergency/Day Care suite presently under construction.

The applicant must have demonstrated leadership and administrative skills, post grad in O.R. and past experience as a Head Nurse or Supervisor. Must be eligible for B.C. Registration.

Cranbrook and District Hospital is a 130-bed hospital in the East Kootenays with many winter and summer recreational facilities.

Qualified applicants apply in writing to:  
 Mrs. P.N. Janzen  
 Director of Patient Care  
 Cranbrook and District Hospital  
 13-24th Ave. N.  
 Cranbrook, British Columbia  
 V1C 3H9

### Canadian Red Cross Society Blood Transfusion Service Pheresis Nurse

An administrative position is available at the National Office to co-ordinate the pheresis programme of the Canadian Red Cross Blood Transfusion Service.

Based in Toronto but travel involved to seventeen Blood Transfusion Centres across Canada. Will work actively with Centre Medical Directors and Pheresis Nurses regarding local operations, and with Director of Medical Services and Director of Nursing at the National level.

Applicants must have two years practical experience in automated cell and plasma pheresis and be eligible for Ontario Registration.

Applicants are requested to submit curriculum vitae to:

Mrs. Marjorie Ferguson  
 Director of Nursing  
 Canadian Red Cross Society  
 95 Wellesley Street East  
 Toronto, Ontario  
 M4Y 1H5

### Hotel Dieu Hospital St. Catharines, Ontario Requires a Head Nurse-Urological Operating Room

#### The Position:

Reports to the Surgical Co-Ordinator, and is responsible for the on-going planning, organizing, evaluating and directing of nursing care for a Urological O.R. The O.R. consists of two Endoscopy Rooms and one major Operating Room serving approximately 2,500 patients per year.

#### Qualifications:

The successful applicant will be a Registered Nurse with a current Ontario Certificate of Competence who has recent experience and up-to-date knowledge of Urological procedures and who has demonstrated sound management and communication skills during their recent employment.

This is an ideal career opportunity for a management oriented individual who is interested in advancement within Urology.

Please apply by resume, in confidence, stating your experience, qualifications and salary requirements to:

Director, Personnel/Staff Development  
 Hotel Dieu Hospital  
 155 Ontario Street  
 St. Catharines, Ontario  
 L2R 5K3

### Registered Nurses

Applications are invited for full time and part time employment at Oshawa General Hospital, a 600 bed hospital, 48 kms. East of Toronto.

Successful candidates must be registered in Ontario.

Services provided include:

Medicine	Paediatrics
Surgery	Intensive Care
Obstetrics	Coronary Care
Emergency	Out-Patients
Chronic/Rehabilitation	

Salary Range: (Full time) \$1,450.00 –  
 \$1,676.00 (monthly)

Inquiries may be directed to:

Personnel Services  
 Oshawa General Hospital  
 24 Alma Street  
 Oshawa, Ontario  
 L1G 2B9

# Choose a Nursing Career in Canada's Ocean Playground



The Victoria General Hospital, Halifax, Nova Scotia is the Maritime's largest teaching hospital. Close association with Dalhousie University and our own extensive continuing education program provide excellent opportunities for learning and career development.

The Victoria General Hospital offers a variety of nursing specialties for experienced people looking for a professional environment and challenge. Victoria General Nurses have full civil service benefits.

- **GENERAL DUTY NURSES** work in our 28 general nursing units, each of which have specific sub-specialties in Medicine and Surgery.
- **INTENSIVE CARE NURSES** are part of five specialized units such as Coronary, Cardiovascular, Medical, Surgical and Neurosurgery.
- **SPECIALTY AREA NURSES** work in the Burn Unit, Renal Unit, Emergency, Operating Room, Recovery Room or Out-Patients.
- **NURSING ADMINISTRATION.** We encourage promotion through an on-going program of leadership development.

Please quote Competition Number: 80-310.  
 For details on nursing opportunities contact:  
 Mrs. Betty Elliot, R.N.  
 Personnel Department, Victoria General Hospital  
 5788 University Avenue  
 Halifax, Nova Scotia B3H 1V8  
 Telephone: 1 (902) 428-3484





- Join the Team providing leadership in Provincial Public Health Nursing Programs.
- Meet the professional challenges of developing, promoting and evaluating programs; conducting program research, staff development and providing consultation in a program specialty.

### Three Positions:

- Consultant to Northern Regions with a specialty in Primary Care Nursing
- Consultant in Maternal & Child Health Programs
- Consultant in Staff Development Programs

### Qualifications:

Master's degree in Community Health Nursing with appropriate specialty and directly related experience, demonstrated leadership skills and knowledge in research methodology. Positions located in Winnipeg, frequent travel throughout province required.

Salary up to a maximum of \$32,280, commensurate with qualifications.

Competition No. CN-3013. Closing Date: Immediately.

Apply to:

Department of Health  
Personnel Management Services  
270 Osborne St. North  
Winnipeg, Manitoba  
R3C 0V8

**MANITBA**

**OPPORTUNITY**

**Alberta**

### Community Mental Health Nurse—Lacombe

Lacombe is a thriving community of 5,000 with excellent access to Red Deer and Edmonton. Supported by interdisciplinary team resources, you will function as a primary therapist, responsible for comprehensive assessment and treatment of complex emotional and behavioural disorders. You will also be involved in public education and community development.

### Qualifications:

B.Sc.N. preferred, but R.N. or R.P.N. with experience will be considered. Must be eligible for registration with approved association(s) in Alberta. A valid Alberta driver's license and automobile are required. Mileage will be paid.

### Salary:

Up to \$17,340 (currently under review)  
Competition No. 9184-9 Open until suitable candidate selected.  
Alberta Social Services and Community Health.

For detailed information, request Job Bulletins and apply to:

Alberta Government Employment Office  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4



## DIRECTOR OF EDUCATION

*is required by*

### THE CANADIAN ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS

### RESPONSIBILITIES:

The primary function of this position is to research, identify, and develop the appropriate educational experience directed towards both under-graduate and post-graduate levels; and to organize and ensure the appropriate access by the membership to educational resources involving current, continuing, and developing programs at these levels. The Director of Education as a senior member of the Associations administrative staff will be responsible to the Executive Director. This position will be based at the Associations head office in Ottawa. The position will require extensive travel throughout Canada.

### QUALIFICATIONS:

The applicant must have an interest in education relative to professional development; preferably should have prior experience in adult education, and a technical background in medical radiation technology, or similar experience within other health professions. A command of both the English and French languages would be an asset.

### OPPORTUNITY:

This challenging career is open to a self-motivating person with a demonstrated ability to function at an administrative level, and whose major interest lies in the educational process.

### BENEFITS:

Standard CAMRT employee package.

### SALARY:

Commensurate with experience and qualifications.

Applications must be submitted in writing including a curriculum vitae, a minimum of three references who can be contacted if necessary and a brief expression of personal views on continuing education as related to Allied Health Disciplines, to the Executive Director, C.A.M.R.T., Suite 410, 280 Metcalfe Street, Ottawa K2P 1R7 Canada postmarked not later than November 15, 1980. All applications will be treated in confidence.



Royal Inland Hospital  
Kamloops, B.C.

### Registered Nurses

Applications are invited for staff additions to Medical-Surgical Nursing, Psychiatric, Intensive Care, Neuro Services, Obstetrics and Rehabilitation Unit.

400 Bed Accredited Acute Care Referral Hospital.

Active Inservice Programmes with Clinical Instructors For Staff Development.

1980 Salary—\$1624-\$1889 per month.

Benefits—As Per R.N.A.B.C. Contract.

Eligibility For Registration in British Columbia Essential.

Kamloops, a rapidly expanding industrial area with population of 65,000 known as the Sunny Sportsman Paradise-Hub City of British Columbia is served by the Trans Canada Highway, both major Railways and Airline Services. Kamloops offers a large variety of winter and summer activities including excellent skiing, golfing, boating, fishing, camping, horseback riding, flying, drama, concerts, and active adult education programmes. It is the site of Cariboo College, one of the Regional Colleges, its nursing programme is affiliated with the Royal Inland Hospital.

Apply to:

Personnel Director  
Royal Inland Hospital  
Kamloops, British Columbia  
V2C 2T1

### Assistant Director Nursing Education

Opportunity to become part of the nursing management team in a progressive 616-bed, fully accredited, acute care facility located in southwestern Ontario.

Kitchener-Waterloo Hospital invites applications for the position of Assistant Director Nursing Education.

The successful applicant would report directly to the Director of Nursing and would be responsible for co-ordination of all phases of nursing education, including orientation, in-service, and continuing education.

#### Qualifications

- Master of Science Degree in Nursing preferred. Bachelor of Science Degree in Nursing with previous inservice education experience would be considered.
- Minimum of five years experience in the health care delivery system.
- Knowledge and demonstrated skills in adult learning, human relations and management.
- Eligible for registration in the Province of Ontario.

Position vacant September 1, 1980.

Please submit resume to:

Director of Nursing  
Kitchener-Waterloo Hospital  
835 King Street West  
Kitchener, Ontario  
N2G 1G3

### Operating Room Clinical Coordinator

Applications are being accepted for the above position. The incumbent will provide leadership in the development and implementation of current clinical practice for the area, and be responsible for its administration.

#### Qualifications

- Registered Nurse
- Demonstrated highly successful work performance within the specified field
- Demonstrated skills in leadership and interpersonal relations
- Demonstrated managerial ability
- Bilingualism an asset

Please apply in writing or telephone:

Director of Personnel  
Laurentian Hospital  
41 Ramsey Lake Road  
Sudbury, Ontario  
P3E 5J1

522-2200, ext. 307

### Head Nurse

#### Medical Nursing

##### Vancouver General Hospital

Applications are invited for the above position. The successful applicant will be responsible for providing innovative and creative leadership in the development of clinical practice within the unit by teaching, consulting and demonstrating specialized nursing skills. She/he is responsible for the quality of nursing care and the nursing administration of the unit.

The incumbent must be eligible for registration in B.C. and have experience in the specific clinical field, hold a BSN or equivalent post basic education. This person must demonstrate skill in leadership and interpersonal relations. Salary and benefits in accordance with the RNABC contract.

Please submit resume to:

Mrs. J. MacPhail  
Employee Relations  
Vancouver General Hospital  
855 West 12th Avenue  
Vancouver, British Columbia  
V5Z 1M9



## University of British Columbia

Health Sciences Centre Hospital

Extended Care Unit

requires

### Clinical Nursing Consultant—Education

Reporting to the Director of Nursing, plans and implements orientation and on-going in-service programs for nursing and other staff members, coordinates pre-admission assessment activities, provides direct patient care to selected patients as arranged, facilitates clinical nursing research, participates in School of Nursing activities in the unit as requested, represents E.C.U. in Nursing Education areas and maintains an effective working relationship with nursing and other health professionals. Requires Master's degree in Nursing or Nursing Education, registration with the RNABC, evidence of clinical competence in the care of elderly/disabled patients demonstrated skills in program planning, implementation and evaluation and successful work experience in clinical nursing and nursing education. Salary and benefits according to RNABC collective agreement.

Applicants should submit detailed resume to:

Coordinator of Hospital Employment  
Health Sciences Centre Hospital  
University of British Columbia  
Vancouver, British Columbia  
V6T 1W5

Position open to both male and female applicants.

## Assistant Nursing Supervisor

### Medical Nursing

Vancouver General Hospital

Applications are invited from Registered Nurses for the above regular and temporary vacancy. The Assistant Supervisor provides innovative and creative leadership in the development and implementation of current clinical practice for the Nursing Division.

Duties include, evaluating and maintaining established standards of nursing care, planning and organizing inservice and continuing education programs, performance evaluation, budget controls, recommendations regarding staff selection. The position involves working evenings and night shift as well as rotating days off.

Applicants must be eligible for registration in B.C. and have a BSN or equivalent plus demonstrated successful work experience within the Medical Nursing field. Demonstrated skills in leadership, interpersonal relations and managerial ability essential.

Please submit resume to:

Mrs. J. MacPhail  
Employee Relations  
Vancouver General Hospital  
855 West 12th Avenue  
Vancouver, British Columbia  
V5Z 1M9

## Registered Nurses

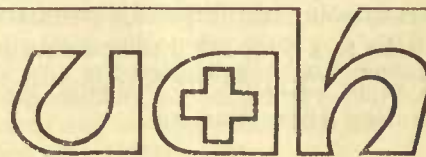
1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including.

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education Programs. Post Graduate Clinical Courses in Cardiovascular—Intensive Care Nursing and Operating Room Nursing.

Apply to.

Recruitment Officer — Nursing  
University of Alberta Hospital  
8440—112th Street  
Edmonton, Alberta  
T6G 2B7



University of  
Alberta Hospital

Edmonton, Alberta





## General Hospital

St. John's, Newfoundland

A completely modern teaching hospital requires an **Operating Room Manager**.

This 500-bed General Hospital is the major teaching facility for the Medical School of Memorial University of Newfoundland.

Services offered:

**Critical Care (Medical-Surgical), Coronary Care, General Surgery, Urology, Gynecology, Psychiatry, Medicine, Nephrology, Clinical Teaching, Neurosciences, Cardiology, Cardiovascular Surgery, Orthopedics, Hemodialysis (Kidney Transplants), Emergency and Out-Patient Services, Active Rehabilitation Program (Adult).**

The Staff Development and Training Department offers ongoing lectures and demonstrations in addition to a 6 month diploma course (twice yearly) in—Critical Care Nursing, Neurosciences, Operating Room Nursing.

Located in St. John's, Newfoundland - the oldest city in North America with a population of 120,000, offering cultural and recreation activities in a friendly atmosphere.

Fishing, hunting, boating available approximately 10-14 miles outside the city.

For information regarding salary and other conditions of employment write or call:

**Director of Nursing**  
**General Hospital**  
**Prince Philip Drive**  
**St. John's, Newfoundland**  
**A1B 3V6**

Telephone No.: (709) 737-6307

## Director of Nursing

The University of British Columbia  
Health Sciences Centre Hospital  
Extended Care Unit

Applications are invited for the position of Director of Nursing for the 300-bed Extended Care Unit, Health Sciences Centre Hospital, University of British Columbia. This long term care unit is part of the 600-bed university health sciences centre complex. An appointment in the School of Nursing accompanies the position.

### Qualifications:

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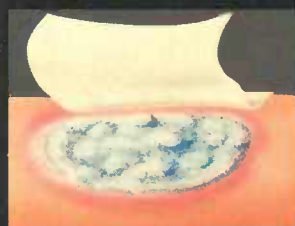
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#### References

1. Lim LT, Michuda M, Bergan JJ. *Angiology* 29:9, Sept 1976.
2. Bewick M, Anderson A. *Clin Trials J* 15:4, 1978.
3. Soul J, Bitt J. *Clin Pract*, 32:8, June 1976.
4. DiMascio S RN. Decubitus Care A New Approach: A Nursing Responsibility, on file at Pharmacia (Canada) Ltd.

\* Reg. T.M.



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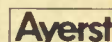
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# The Canadian Nurse

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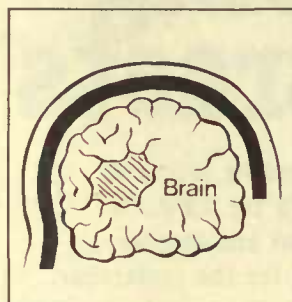
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*The Canadian Nurse* welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

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# input

## Patient privacy

One of the most sensitive, intimate areas of person-  
ality is privacy. Loss of it  
debases a person; one loses  
self-respect, dignity and the  
feeling of worth.

As an MS victim, I need  
assistance in washing and  
dressing. After a shower, I am  
dressed not ten feet from a  
door that may open unexpect-  
edly, and I cringe waiting to  
be dressed. Though I have no  
objection to being bathed by  
a nurse, I do object to others  
coming and going while this is  
occurring. Unlike you, I can-  
not quickly run to another  
room or pull on a housecoat.

A disabled person has  
difficulty maintaining an ac-  
ceptable level of privacy.  
Nurses who recognize and pro-  
vide for a patient's need for  
privacy can only add to the  
stature of the profession.  
—B. Francis, (pseudonym),  
Cambridge, Ontario.

## Reducing bladder infection risk

I enjoyed very much  
Lori Whittington's article  
"Bladder Retraining" (June  
1980). It outlined bladder  
function and nursing care very  
clearly, but I would like to  
comment on the suggestions  
related to infection control.

I agree that an indwell-  
ing catheter is a portal of  
entry for bacteria, but fre-  
quent changing of the cath-  
eter only places the patient at  
greater risk.

The experience of my  
colleagues and myself with  
catheterized extended care  
patients has shown that the  
bladder of any patient with  
an indwelling catheter will be-  
come colonized with bacteria  
within a few days of cath-  
eterization.

Colonization is the pre-  
sence of poly bacteria in the  
urine in numbers greater than  
100,000 per ml. of urine in  
the asymptomatic patient. No  
amount of catheter change  
will prevent this.

However, the trauma of  
catheterization or catheter  
manipulation can result in a  
break in the normally pro-  
tective mucous membrane,  
allowing colonizing bacteria  
to escape into the blood  
stream. This leads to bacter-  
emia, septic shock and even  
death. Reducing the numbers

of catheter changes reduces  
the risk of trauma and subse-  
quent infection.

As long as the cath-  
eterized patient is asymptomatic  
of infection, he should not  
be treated with antibiotics as  
the organisms will recur and  
will become resistant. How-  
ever, if the patient becomes  
symptomatic, treatment  
should begin immediately.

High doses of ascorbic  
acid will not prevent coloni-  
zation. Instead of colonizing  
with bacteria which like more  
alkaline environments, the pa-  
tient will colonize with acid-  
loving bugs. Also it takes a  
very large amount of cran-  
berry juice and/or acid-  
forming fluids to significantly  
alter the pH of urine. The  
best solution is to provide the  
large amounts of fluid sugges-  
ted: 2000-3000 cc daily. This  
keeps the urine dilute and ir-  
rigates the urinary system  
"by mouth".

An excellent reference  
on this subject is "Detection,  
Prevention and Management  
of Urinary Tract Infections"  
3rd Edition, by Calvin M.  
Kunin, Lea and Febiger,  
Philadelphia, 1979.

—Roberta Clark, staff educa-  
tion department, Saint John  
Regional Hospital, Saint John,  
N.B.

(continued on page 68)

## We were wrong.

A photo caption on page 25 of the  
September issue of CNJ incorrec-  
tly identifies Lillian E. Pettigrew as  
Pearl (Penny) Stiver, executive  
director of CNA from 1952 to  
1963 and also a founding member  
of the Canadian Nurses Founda-  
tion. Lillian Pettigrew, pictured  
with a third founding member of  
the CNF, Alice Girard, was asso-  
ciate executive director of CNA  
from 1964 to 1972. Our apologies  
to both.

## DON'T FORGET

The Association of Registered  
Nurses of Newfoundland will hold  
its 1980 annual meeting at the  
Holiday Inn, St. John's, New-  
foundland, November 3 to 5 and  
the annual meeting of L'ordre des  
infirmières et infirmiers du  
Québec will be held November 24  
to 26 at the Bonaventure Hotel,  
Montréal, Québec.



## YOU AND THE LAW

Student  
nurses  
and the law

Corinne L. Sklar



Student nurses are, by definition, less experienced and less knowledgeable than registered nurses. But are they equal in the eyes of the law? Is the standard of care required by law the same for both?

Nursing care is judged by the standard reasonably expected of an ordinary, reasonable and prudent professional nurse of similar training and experience. This legal standard is an objective comparison, the yardstick by which all nursing conduct is measured. A nurse who delivers patient care that falls below this standard is considered negligent in the performance of her professional duties, negligence which might result in the imposition of legal liability by a court against her or the hospital employer if a lawsuit is brought by the patient who suffered harm as a result of this conduct. Such substandard nursing care could also result in a finding of professional misconduct or incompetence by that nurse's professional regulatory body.

The student nurse, as is any individual, is personally responsible in law for his or her own negligent acts or wrongs. When student nurses carry out their nursing responsibilities during the course of their clinical experience, they must perform their duties with the same degree of competence that would be required of a registered nurse. This higher standard is necessary to protect the patient: to do otherwise would be to subject the patient to a lower standard of care merely because he is receiving care from a nursing student. The patient is entitled to receive a professional standard of care regardless of the educational status of the person delivering it. This is true of all personnel delivering patient care or treatment — physicians, physical or occupational therapists, dietitians, technologists, dentists, psychologists and social workers.

The public expects nurses to have special skills and competence, acquired by virtue of their special training and experience. Thus they must deliver care that measures up to the degree of proficiency expected of a member of the profession. While the law does not demand perfection of nurses, and a Court always considers all of the circumstances of the case, nevertheless, a nurse must use reasonable care and proficiency in exercising her professional responsibilities. This applies also to student nurses.

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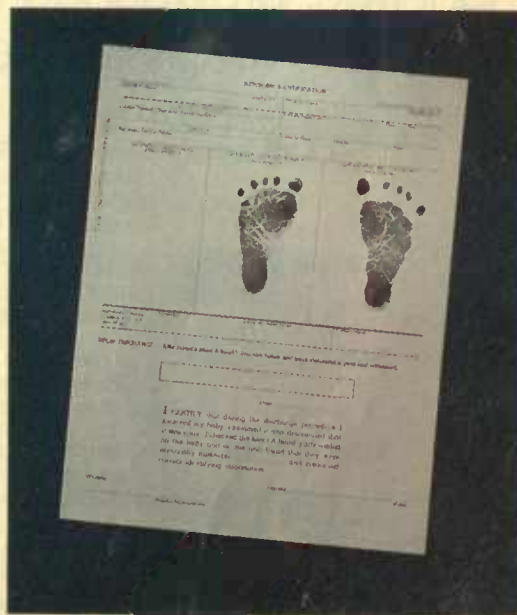
And, indeed, in the case described here, positive identification was obtained only after law-enforcement officials compared the baby's footprints with a set made at the time of birth, using the Hollister FootPrinter system.

Of course, for Hollister, footprinting is only one of many ways we're leaving our mark on the health-care community.

Hollister products touch millions of people. Nearly one million ostomates, for example, lead more meaningful lives due to Hollister technology.

And we're still seeking answers. Because someday, that infant we helped reunite with his family may need our assistance once again.

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In general, the requirements of our modern society dictate a need for encouragement of beginners in all fields of endeavor. Counterbalancing this, however, is the obvious necessity of protecting society from the errors and omissions of these beginners, as well as compensating the victim for any loss suffered. A student driver, for example, is held to the standard of the reasonable and prudent motorist; to require less would subject pedestrians and motorists alike to unreasonable risk of harm on the nation's streets and highways. But the law does not leave the student to fend for himself: in order to protect the interests of both the student and the public, a legal responsibility to provide students with supervision and guidance during the learning process is imposed upon the employer, school or other responsible individuals such as clinical instructors.

The student's clinical instructor is responsible for the student's assignments; student supervision must meet the standard reasonably expected of a prudent clinical instructor of similar experience and training. If an instructor failed to meet this standard and if there were a finding that her student's conduct was negligent and caused harm to a patient, that instructor could be held legally liable for the negligence of the student nurse. The clinical instructor, like registered nurses and student nurses, also has an objective standard of care by which her supervision of students is gauged; if this supervision falls below the standard of the reasonable and prudent clinical instructor, then that instructor is negligent.

It is important to recognize that instructor negligence and student nurse negligence are not inextricably linked: student negligence does not automatically impose legal liability upon the clinical instructor. If a student nurse is negligent but the supervision that student received met the legal standard of care for such supervision, then a Court finding of liability would be directed against the student. The instructor would not be liable for the negligence of the student.

Creighton refers to a U.S. case involving a first year student administering medication I.M. to a patient with Buerger's disease whose right sciatic nerve was severely injured. The patient recovered a substantial judgment against the hospital because, although first year students were permitted to give injections under supervision, in this instance adequate supervision had not been given.<sup>2</sup>

In another American case, *Walker v. Graham et al.*,<sup>3</sup> an inexperienced orderly successfully sued the hospital after contracting hepatitis; the illness occurred after his skin was pierced by needles protruding through a bag of garbage he was carrying to disposal. The court found that the hospital had failed in its duty to teach inexperienced employees how to avoid dangers connected to their employment.



Obviously, hospitals can have liability to as well as liability for students. The hospital may incur liability as a result of student nurse negligence because it has a duty to the patient to provide competent and qualified personnel to deliver care. If the hospital provides a student nurse who is negligent, it has breached this duty to the patient. Hospitals are also vicariously liable for the negligence of employees acting within the scope of their employment;<sup>4</sup> if the student nurse is a hospital employee, then the hospital's vicarious liability follows. In such a case, it is the relationship between employer and employee, not the status of "being a student", that dictates the vicarious liability of the hospital employer.<sup>5</sup>

If a nursing school is directly connected to a hospital that supervises, controls and perhaps pays (or otherwise benefits) its student nurses, then the employment relationship is clear: the hospital generally provides room and board, training and supervision etc. in exchange for the student's services on the hospital's ward units for the benefit of that hospital. In such hospital training programs, the vicarious liability of the hospital for the negligence of employees including student nurses is clear.

In *Harkies v. Lord Dufferin Hospital*,<sup>6</sup> a student nurse with nine months experience was caring for an infant ill with pneumonia. The infant was placed in a steam crib and steam inhalation was achieved by means of a hose connected to a kettle. The other end of the hose was placed in the crib under a canopy. The infant suffered severe scalding of his back and legs which left him with a permanent limp. No one, including the student nurse, could explain how the injuries had occurred.

The trial judge noted that if the child had tampered with the hose, the scalding would have occurred on the upper part of the child's body. He stated that, on the evidence received, he accepted that the equipment was safe if it was used correctly and that the student nurse had been instructed in its proper use. He held the hospital liable for the injuries because, in the absence of any other explanation, they must have resulted from negligent use of the equipment by the nursing student.

Most nursing students today are not hospital employees since schools of nursing are usually separate from the hospital in which the student may have all or part of her/his clinical experience. These students pay tuition fees as well as their room and board and maintenance. The nursing service provided by these students is considered educational in nature rather than a return for maintenance provided by the hospital. Here, the question of a hospital's vicarious responsibility for the negligence of a student nurse would depend upon a finding that the student is a hospital employee. The agreement

between the school of nursing and the hospital providing clinical experience would be another important factor in this determination.

In some provinces, legislation exists which provides that students, including student nurses, are hospital employees. For example, in Ontario, s. 61 of Regulation 729 under *The Public Hospitals Act*<sup>7</sup> includes student nurses in the definition of hospital employees. The thrust of that section of the Regulation which governs hospital management, deals with the regulation and supervision of the personal health of hospital employees in order to safeguard the health of all those in the hospital be they employees, patients or visitors. Because other sections of The Act and the regulations thereunder also refer to students, it might be argued that student nurses can be considered hospital employees even though the services they provide are educational in nature rather than in exchange for the maintenance benefits that hospitals used to provide.

The hospital's duty to provide competent and qualified nursing staff to deliver care to patients is met, in part, by the head nurse who is responsible for the work assignments and the nursing care delivered to the patients on the unit. It is the head nurse who supervises those delivering care on the unit and she therefore also has a role in the observation and supervision of the care delivered by students on the unit.

Where a head nurse finds that a student nurse is not delivering care that meets the required standard, this must be corrected. The clinical instructor should be informed and the student given additional instruction and/or supervision. Other nurses working on the unit should also bring to the attention of those in charge circumstances of student nursing care which they observe to be wanting, for example, failure to hand wash or breaks in sterile technique. Failure to deal with problems like these creates an unreasonable risk of harm to the patients and leaves the hospital open to legal liability for the negligence of its employees and for lack of proper supervision of beginners. The protection of the interests of the patient must be paramount.

Where student nurses are delivering care, the nursing staff on the unit should be aware of and have some guidelines as to the scope of activities the students are permitted to undertake. Students should be specifically instructed not to undertake to perform nursing care for which they have not received instruction. Students, like RN's, should be instructed to ask for assistance if they are uncertain about the performance of any procedure, treatment or care generally. The ward staff should encourage the students to request assistance when necessary; even though this may be perceived as an additional burden on staff already over-burdened, the primary goal of protecting the patient's safety, health

and well-being cannot be overlooked. On graduation, students become colleagues in delivering patient care and time spent assisting the competence of a student today means a competent professional nurse later on. In addition, student nurses as well as registered nurses should always advise those making the order of situations in which they feel they are not competent to act.

As Creighton so aptly states:<sup>8</sup>  
"The inherent responsibility of the nurse who supervises others — whether it is nursing students, registered professional nurses, practical nurses, aides, orderlies, or attendants — is to determine which of the patients' needs can be safely entrusted to a particular person and whether or not the person to whom the duty is delegated or assigned is competent only if personally supervised." (emphasis added)

The health, safety and well-being of the patient are at stake; the required standard of nursing care must be met to protect the patient. Staff nurses, clinical instructors and student nurses must work together to deliver competent and quality nursing care to the patients in their trust.

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\*Not verified



Author Corinne L. Sklar is a lawyer and practices law in Toronto, Ontario. She is legal counsel with The Imperial Life Assurance Company of Canada. Prior to her law studies, she obtained her BScN and MS degrees in nursing from the University of Toronto and the University of Michigan respectively.



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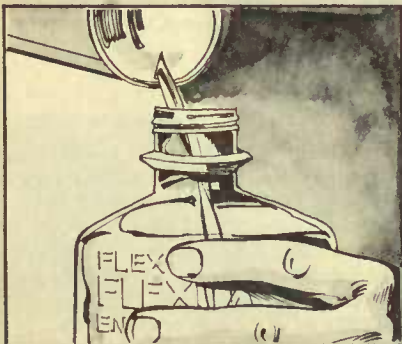
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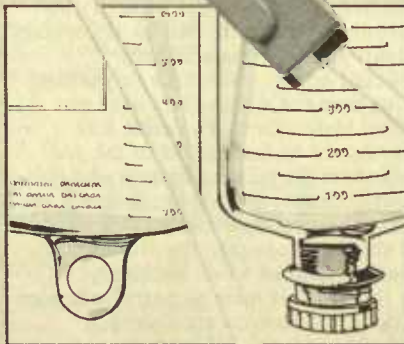
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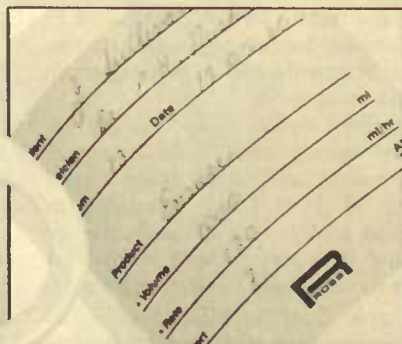
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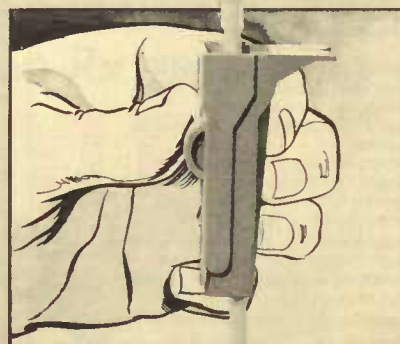
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### CONTRAINDICATIONS:

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### ADVERSE EFFECTS:

In contrast to salicylates, gastrointestinal irritation rarely occurs with acetaminophen. If a rare hypersensitivity reaction occurs, discontinue the drug. Hypersensitivity is manifested by rash or urticaria. Regular use of acetaminophen has shown to produce a slight increase in prothrombin time in patients receiving oral anticoagulants, but the clinical significance of this effect is not clear.

### PRECAUTIONS AND TREATMENT OF OVERDOSE:

The majority of patients who have ingested an overdose large enough to cause hepatotoxicity have early symptoms. However, since there are exceptions, in cases of suspected acetaminophen overdose, begin specific antidotal therapy as soon as possible. Maintain supportive treatment throughout management of overdose as indicated by the results of acetaminophen plasma levels, liver function tests and other clinical laboratory tests.

N-acetylcysteine as an antidote in acetaminophen overdose is recommended. However, its use at present is considered experimental. More detailed information on the treatment of acetaminophen overdose, including the availability of N-acetylcysteine, the preparation of N-acetylcysteine for administration as an antidote, recommended dosage regimen and acetaminophen assay methods is available from JOHNSON & JOHNSON Limited/Limitée, 890 Woodlawn Road West, Guelph, Ontario N1H 7L4, or contact your nearest Poison Control/Information Centre.

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Children 10-14 years: 1.5 mL 3 times daily  
5-9 years: 0.6 mL 4 times daily  
2-4 years: 0.3 mL 4 to 5 times daily

Children under 2 years: As directed by physician

Adults: 3 mL 3 times daily or as directed by physician

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## US, Canadian nurses attend perinatal symposium

### Special Report

by

Sandra LeFort

Obstetrical, pediatric and neonatal nurses from across the US and Canada came together at the National Symposium of Perinatal Nursing held in Montreal, August 7-10. Three hundred American nurses came from as far away as California and Texas, with a large representation from the mid-west and from New York state. Sixty Canadian nurses primarily from the Maritimes and central Canada also attended this gathering of specialty nurses.

The four-day meeting provided a forum for discussion of advances in perinatal nursing and current clinical management. In all, 25 lectures and 32 workshop sessions were presented on a wide variety of topics including:

- genetic screening and prenatal diagnosis of intrauterine growth retardation
- care of the pregnant diabetic and her infant
- neonatal infections
- fetal heart rate monitoring
- pregnancy after 35
- pros and cons of circumcision
- the high risk pregnancy
- necrotizing enterocolitis.

Lectures were presented in the morning followed by a question period and then by workshop sessions in the afternoon.

### Meeting highlights

All speakers were experts in their field; many had conducted recent research into their particular specialty area of perinatal care. The lectures were primarily a review of current literature and research on the subjects along with the clinical management and protocols used in specific hospitals.

Dr. William On, professor of pediatrics and obstetrics, Brown University in Rhode Island discussed patent ductus arteriosus (PDA) in the low-birth-weight infant. He stated that babies over 1500 gm, treated with Indomethacin had closure of the ductus in 70-80 per cent of cases. Smaller babies often did not respond satisfactorily to the prostaglandin synthetic compound.

Recent studies also strongly recommend conservative fluid intake if PDA is suspected. Babies given liberal amounts of fluid (160 ml/kg/day or more) had a high risk of developing or worsening their left to right shunt. The message to nurses was "watch the fluid".

Frank Boehm, MD, director of fetal intensive care and associate professor of obstetrics and gynecology at Van-

derbilt University in Tennessee, spoke on the controversy surrounding fetal heart rate monitoring in labor. A strong advocate of fetal monitoring, Boehm reviewed the past 10 years stating that fetal monitoring had decreased the antepartum death rate to about five per thousand deliveries, as opposed to seven to eight per thousand where fetal monitoring is not used. He stated that the alarming rise in Caesarean sections in the US and Canada over the last decade was due to poor interpretation of the monitoring data by physicians and nurses. Now, with greater expertise in the use of monitors, the C-section rate is going down and many babies in fetal distress due to cord compression, utero-placental insufficiency or infection, are being saved.

Prolonged apnea and sudden infant death syndrome (SIDS) was discussed by William Kanto, associate professor, department of pediatrics at Emory University in Atlanta, Georgia. He gave a chronological history of the progress in knowledge related to SIDS. Of special interest was one retrospective study which tried to see whether these babies really had been "normal" prior to their death.

In comparing SIDS victims to their living siblings, mothers reported that the SIDS infant:

- had been less active than her other children
- was less responsive to stimuli
- was easily exhausted especially with feedings
- possessed a different and less varied cry.

In another collaborative study done in the United States, 60,000 pregnancies were followed with 125 babies developing SIDS. The results indicated that there was an increased incidence in babies of young, smoking mothers; that the SIDS victims had a low Apgar at birth and many required resuscitation; and that some had subtle neurological signs.

In discussing possible treatment for high risk SIDS victims, Kanto suggested that Theophylline should be given to the preterm infant who has respiratory problems, home monitoring with electronic devices could be initiated and in all cases strong family support was needed.

### Canadian content

A number of nurses and health professionals from the Montreal area presented excellent lectures and seminars to the group, among them:



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# Why complicate simple analgesia?

## **ASA** side effects (at normal doses)

### Adverse effects

...on hypersensitive individuals<sup>3,4</sup>

...on the gastrointestinal tract<sup>7,8</sup>

...during pregnancy<sup>9-11</sup>

...of concomitant use with other drugs<sup>2b</sup>

...on the blood<sup>5,6</sup>

...resulting in iron-deficiency anemia<sup>5,12</sup>

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- Judith Collinge, nurse researcher, neonatal intensive care unit, Montreal Children's Hospital who discussed nursing management of hyperbilirubinemia;
- Valmai Elkins, director of the obstetrical program, School of Physio and Occupational Therapy, McGill University who spoke on pain control methods in labor;
- Frances McLean, information officer, perinatology at Royal Victoria Hospital who discussed physical and gestational age assessment of the newborn;
- Anne Kiss, instructor of family structure and community health nursing,

Concordia University who presented the challenges of teenage pregnancy;

- Joula Hatherall, coordinator of the Childbirth Education Program in Montreal who discussed childbirth education.

Of special interest was a seminar presentation by a team from Montreal's Royal Victoria Hospital. Marion Copp, nurse clinician teacher, Nancy Fuller, director of social services and psychiatrist Catherine La Roche presented recent findings on reactions to stillbirth and neonatal death.

They explained that until two years ago, health care personnel offered

no special support to parents of stillborn infants. Parents' requests to see and touch their dead baby or to have a photograph of their infant were viewed as morbid and were discouraged. Feedback to nursing staff from several parents about how difficult it was to cope with stillbirth led to the formation of a team approach to deal with the crisis of stillbirth and neonatal death.

The importance of parents seeing and touching their infant, taking photographs, the meaning of a ritual such as a funeral and the importance of empathetic health care personnel were highlighted.

#### Symposia Medicus

The Symposium was sponsored by Symposia Medicus, a private, non-profit association that organizes programs to meet the continuing education requirements of physicians and nurses in specialty areas. Speaking on behalf of Symposia Medicus, Dwight Stump, vice-president, stated that "a private corporation such as ours can do a good job in the area of continuing medical and nursing education because we can use expertise from across the country". The Perinatal Symposium took over a year of planning. Stump explained that surveys are conducted across the US to identify the topics of current interest.

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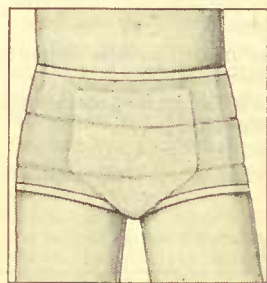


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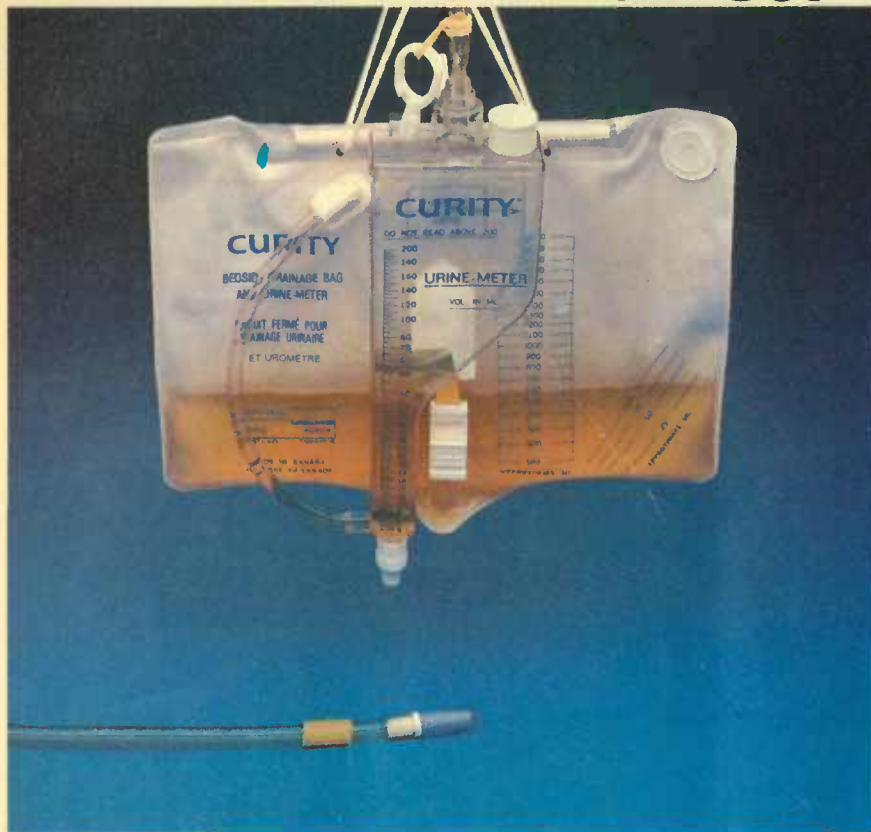


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By **H. Robert Patterson**, BS, MS, Pharm.D., Prof. of Microbiology and Biology, San Jose State Univ., San Jose, CA; **Edward A. Gustafson**, BS, Pharm.D., Pharmacist, Valley Medical Center, San Jose, CA; and **Eleanor Sheridan**, RN, BSN, MSN, Asst. Prof., College of Nursing, Arizona State Univ., Tempe, AZ. 374 pp. Soft cover. \$13.15. April 1980. Order #3522-5.

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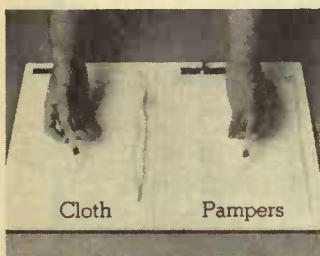
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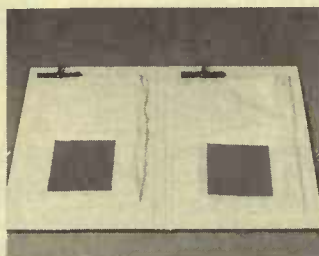
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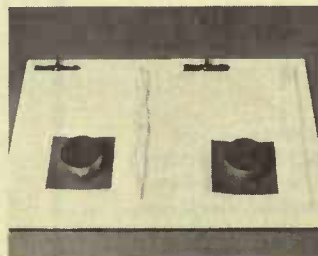


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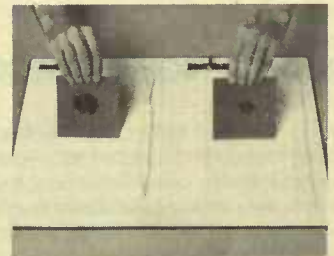
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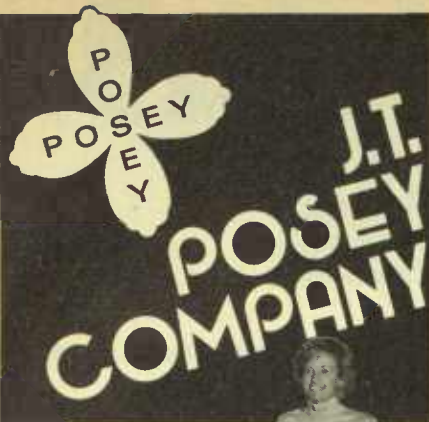
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## Health hotline makes house calls in Halifax



Co-host Deni Sommerfeld with Dave Wright

### Mary-Lou Ellerton

Health information at the turn of a radio dial. That's what Haligonians get when Dalhousie University's School of Nursing and a local radio station join forces.

*Hotline to the health team*, a two-hour, call-in show aired once a month in the Halifax-Dartmouth area, is designed to help the public learn more about community services. Each program is co-hosted by a faculty member of the school of nursing and radio station CJCH's Dave Wright. A different faculty member every month gives each program a different focus.

The show opens with a 20-minute discussion of some aspect of physical and emotional health, usually the faculty member's area of special interest. So far, topics have ranged from food and fitness to human sexuality, from parenting to stress. The phone lines are then opened and listeners are invited to call in questions about their health.

Most of the calls come from women working in the home and for the most part, tend to reflect the difficulties of coping with life crises such as parenthood, menopause, retirement and family sickness.

The success of the hotline comes from the anonymity it provides people; many would be reluctant to ask a health professional the same question in an office setting. One caller confided her distress at her husband's lack of interest in sex after a heart attack and others have expressed concern about their body image and sexuality. All were relieved to find that their concerns were normal.

If the co-host feels that a caller deserves more individual attention, she asks him to call back after the program for further discussion and possible referral.

Besides requests for advice, the program has elicited many calls for information on, or clarification of specific diseases, treatments and drug usage; current public interest in nutrition has also been reflected in the number of calls about vegetarianism and natural foods.

Health professionals, including a physician, nutritionist and a pharmacist, are available by phone hook-up to handle requests for specialized information.

So far, audience response has been enthusiastic. The switchboard usually gets about 12 to 15 calls per show and listeners who don't get through, can mail their questions to the station. The half dozen letters received are answered on the next program.

Moving into its second year, *Hotline to the health team* hopes to introduce more topics related to health and lifestyles such as:

- health for women — cancer, menopause, careers and mothering
- health for the elderly — nutrition, social contact, home care
- health and fitness — exercise, nutrition for athletes, the heart.

*Hotline to the health team* is one of a series of four shows on community service professions. Its sister programs deal with law, consumerism and police protection.

Mary-Lou Ellerton is a lecturer in Medical-Surgical Nursing at Dalhousie University and chairman of the Public Relations Committee which coordinates *Hotline To The Health Team*.



# audiovisual

## Award Winning Films

The John Muir Film Festival (California) is the only festival in the world to exclusively honor films produced for the continuing education of doctors, nurses, paramedics and community health education. This year almost 200 films were entered in 22 different categories and Canadian films took three awards:

*There's No Place Like Home For Health Care*, a series of 12 films produced as a joint project of Saint John Ambulance and the Red Cross, won honorable mention in the rehabilitation category. Peter Cock directed the films and they were produced by Crawley Films Ltd. of Ottawa. The series is designed to teach basic home skills to the public and thus reduce the need for hospitalization. It is part of a package that includes handbooks and classroom instruction, and is now being distributed across Canada; for further information contact St. John Ambulance or Red Cross.

*Four Women: Breast Cancer*, produced by the Canadian Broadcasting Corporation and directed by John Kastner, won the festival's oncology award. This film explores the personal experiences of four women having a mastectomy; they, and three husbands speak candidly about their fears, uncertainties and adjustments.

*One of Our Own*, produced by Bill Gough and directed by William Fruet, received honorable mention in the mental retardation category. The story is that of an 18-year-old boy with Down's Syndrome adjusting to a move from a small town to a big city. The film deals with the family's difficulties in coming to grips with the future of this boy. The lead role is played by an actor with Down's Syndrome. The film is available through the Canadian Broadcasting Company.

A catalogue of audiovisual resources in the field of psychiatric-mental health nursing has been developed as a special project of the faculties of Continuing Education and Nursing at the University of Calgary. Compiled by Janice Bell and Sylvia Teare, two nurse educators, the catalogue contains titles and descriptions of audiovisual resources, many of which have been evaluated by them. Names and addresses of distributors are also included. Cost per copy is \$5.00; order from:

Mary Hammond  
Faculty of Continuing Education  
University of Calgary  
2500 University Drive N.W.  
Calgary, Alberta T2N 1N4.

*Can I Take This If I'm Pregnant* is a brochure published by the Addiction Research Foundation. It is intended as an expectant mother's guide to the use of social and non-prescription drugs. Alcohol, tobacco, caffeine and marijuana are among those discussed; most drugs are discussed under group headings such as analgesics, tranquilizers, etc. Cost of the brochure is 25 cents. It is available from:

Addiction Research Foundation  
33 Russell Street  
Toronto, Ontario  
M5S 2S1

Health and Welfare Canada and the Canadian Pediatric Society have produced an awareness program on breast feeding. This packet of materials contains scientific articles on the uniqueness of human milk and the practical management of breast feeding, lists of resource persons, as well as an attractive wall poster.

Copies of the kit are available from:

Nutrition Education Unit  
Health and Welfare Canada  
Ottawa, Ontario  
K1A 1B4

The Canadian Institute of Child Health has published three reports:

1. Care of Children in Health Care Settings: A Resource and Self-Evaluation Guide
2. Care of Children in Health Care Settings: Play and Play Programs
3. Care of Children in Health Care Settings: Preparation for Hospitalization.

The *Resource and Self-Evaluation Guide* is a manual for use by doctors, nurses, administrators or consumers to assess care on a pediatric unit with more than 20 beds. The question and answer format covers such topics as policy and procedure manuals, maintaining a safe environment, facilities and equipment. It is available in French or English at a cost of \$8.00 per copy.

The *Play and Play Programs* is an information kit for use in setting up a play program or implementing changes in an existing one. It is available in English for \$5.00.

The *Preparation for Hospitalization* resource kit is designed to help parents, teachers, health care professionals and others in implementing a hospital orientation program for children. It is available in English for \$5.00.

All publications can be ordered from:

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## Ten Canadian Nurses Receive Scholarships

This year, ten Canadian nurses have been awarded scholarships totaling \$38,000 from the Canadian Nurses Foundation. Half of the nurses will use their fellowships for doctoral studies, while others will commence or continue studies at the master's level.

The Canadian Nurses Foundation, established in 1962, receives funds and administers fellowships for the preparation of nurses for leadership positions. A total of 215 scholarships have been awarded since its inception. CNF funding is voluntary and depends upon gifts, donations and bequests from individuals and organizations.

The five nurses who will pursue doctoral studies are:

- **Janet Beaton** of Winnipeg, Manitoba. Beaton, who holds a Bachelor of Nursing from the University of Manitoba and a Master of Arts in maternal-infant health from the University of Washington, plans to study at the University of Texas. After graduation, she will return to teaching graduate and possibly undergraduate courses at the University of Manitoba, School of Nursing.

- **Lillian Bramwell** of Belmont, Ontario. Bramwell earned her B.Sc. and MScN in health education and nursing education from the University of Western Ontario. She received her RN diploma at the University of Alberta Hospital in Edmonton. Bramwell plans to return to the Faculty of Nursing at the University of Western Ontario, from which she presently has leave of absence to attend Wayne State University in Detroit.

- **Heather Clarke** of Victoria, British Columbia. Clarke will study at the University of Washington in Seattle. She received her diploma in nursing at Wellesley Hospital in Toronto, a B.N.Sc. in public health nursing from Queen's University and a Masters of Nursing in maternal/child health from the University of Washington. When she finishes her PhD, Clarke plans to resume her teaching responsibilities at the University of Victoria as an assistant professor.

- **Elizabeth Davies** of Edmonton, Alberta. Winner of the Katherine E. MacLaggan fellowship, Davies is presently enrolled in the postmaster's program at the University of Washington in Seattle where she plans to continue her studies. Davies earned her BScN from the University of Alberta and her MS in nursing from the University of Arizona.

- **Lesley Degner** of Winnipeg, Manitoba. Degner will attend the University of Michigan School of Nursing. She holds a BN from the University of Manitoba and a Master of Arts in physiological nursing and philosophy from the University of Washington. Upon completion of her PhD, she plans to return to her teaching position at the University of Manitoba.

Of the five nurses who will pursue studies at the master's level, four received CNF scholarships. They are:

- **Susan Abbott** of Toronto, Ontario. Abbott holds a BScN from the University of Toronto and is currently a teaching assistant at Boston University. She will continue her studies there.

- **Linda Cooper** also of Toronto, intends to study at Boston University. She holds a BScN from the University of Windsor.

- **Margaret Earle** of St. John's, Newfoundland, has been awarded a CNF fellowship of \$2,000 and the Agnes Campbell Neill Memorial award of \$1,000 to pursue graduate studies at the University of Toronto. She received

a BN from Memorial University.

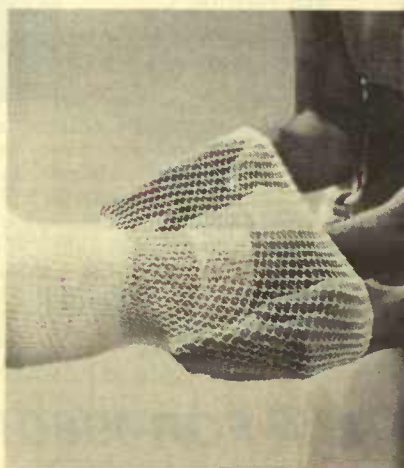
- **Yvette Fliesser** of Ilderton, Ontario. Fliesser will use her scholarship to complete her MScN at the University of Western Ontario where she is currently enrolled in part-time studies. She holds a BScN from UWO.

The winner of the Helen McArthur Canadian Red Cross Society Fellowship valued at \$3,500 is:

- **Beverley Robson** of Melfort, Saskatchewan. Robson, who holds a BScN from the University of Saskatchewan, plans to continue working on her master's degree at Case Western Reserve University in Cleveland, Ohio. She will specialize in community health and education.

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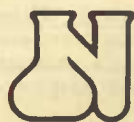
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The purpose of this book is twofold, first, to present current information on commonly ordered laboratory diagnostic tests; second, to organize the data in a form that is orderly and easy to use and understand.

Lippincott. 828 Pages. 1980. \$15.50

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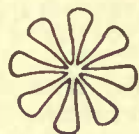
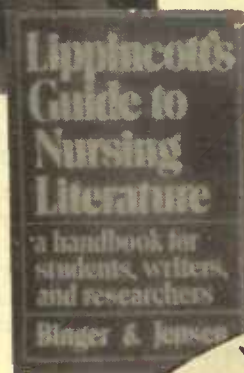
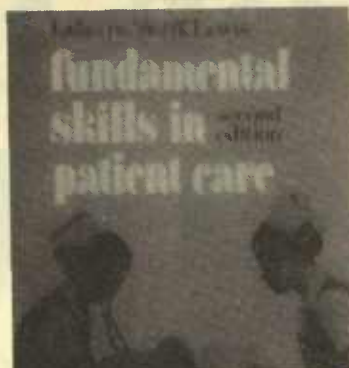
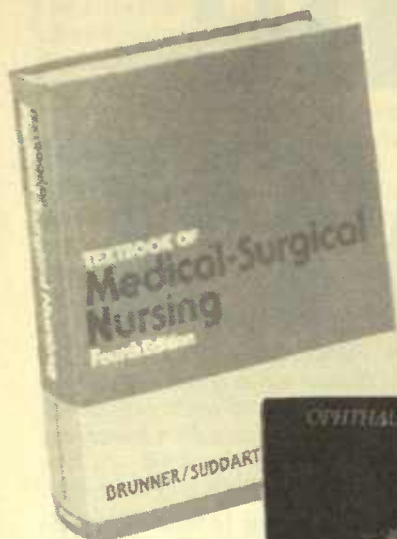
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Nurses are prime candidates for role stress. Current nursing trends have attracted a new breed of students and educated them to expect to function in a greatly expanded role. However, much of the profession still functions with the belief that "a nurse is a nurse is a nurse". The broader educational background of today's nurse has forced her to view the world in a different

context, and therefore has left her role full of uncertainties. In order to cope with the stress brought on by such confusion, nurses must make personal changes as individuals, caring for themselves, so that the profession can then change and alter the systems within which nurses operate.



Basically, there are four areas of our lives in which stress is manifest and which can be altered to decrease stress. They are the psyche, soma, family and social life and our occupational life. They can also be looked at under the subtitles of getting to know yourself; taking care of yourself; getting to know others and putting it all to work. In dealing with each of these areas, you should know the danger signals that the stress of life is really beginning to get to you and how you can cope.

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- **Sleep Disorders** such as insomnia or its converse, the desire to sleep all the time. Either pattern may be accompanied by frequent conflict-ridden dreams reflective of anxiety about professional or personal issues.
- **Depression** which can be displayed in behavior patterns such as apathy, isolation and withdrawal and low self-esteem; lack of interest in work and other people; a sense of anger towards others in the environment; feelings of powerlessness, hopelessness and worthlessness; and clear-cut depression with its signs of early morning wakening, constipation, changes in eating patterns, feelings that life isn't worth living
- **Anxiety** which can be expressed by restlessness, inability to make decisions and a fear of taking on responsibility
- **The use of drugs** such as sedatives, antidepressants, tranquilizers, stimulants.

The best way to deal with these psychological disturbances is to avoid their occurrence. This can be done in a number of ways. For instance, some experts have suggested that a good way of reducing stress in one's life is to take one hour a day to pursue something that really interests you. This is your time to read, walk, bird watch, meditate, garden, engage in physical activity, listen to music—whatever gives you pleasure.



People are often skeptical of the effectiveness of such a measure but this can have particular value for nurses because as a group, we often suffer from low self-esteem. Taking the time to take care of yourself for at least one hour a day, acknowledges that you do indeed have value — you are worthwhile — you are worth the expenditure of your time. Nurses tend to have little difficulty acknowledging that patients and families deserve time but often feel that they aren't really worth the effort. To give themselves pleasure is somehow wrong, hedonistic and selfish and this can lead to guilt.

Depression is closely related to the problem of low self-esteem. As the need to nurture is often socialized into the female, many nurses come into the profession with a strong need to nurture. Women are especially prone to depression because they have not been socialized to think of themselves as primary people; their identity evolves only through caring for others. Therefore, when a woman wishes to get out of the nurturing role, others are threatened and often rebel. This threatens the woman's attempt to stand on her own two feet. She feels she has stepped out of her role and made others unhappy. For their sake, she must resume her passive, nurturing role, which she does, but often with a fair amount of depression and a resentment of this role.

This type of behavior is evident in the young nurse who comes into her first job full of new ideas. As she develops confidence she shares these ideas and gets put down with comments such as "you get paid to work not to think", "if you don't like the way things are then leave, remember the door swings both ways." Gradually the new nurse's self-esteem is eroded, she stops making suggestions, thinks less of herself for doing so and glumly goes about her tasks with a pervasive, low-lying sense of depression. The feeling that you are playing an important role in life both personally and professionally is one of the best ways of enhancing self-esteem and avoiding depression. At least once a day try to praise one of your colleagues who has done a good job. Take a moment to think of one good thing you did each day rather than constantly berating yourself for your inadequacies.

Another aspect of depression has to do with the unmet dependency needs some nurses might have had while growing up. We may have come into nursing wanting to care for others, in part because we never really felt cared for ourselves. That may be why nurses can be such demanding patients: we have a desire to get paid back for all we have given while at the same time, an inability to relax in the dependency role because of a basic fear that no one can really be trusted to care for us.



Problems of low self-esteem and dependency needs can be seen in all levels of nursing, including those at the very top. Some of the hardest working and best nurses are motivated by this sense of low self-esteem and dependency needs which means that they function taking care of others with a fairly high level of depression in themselves. Recognize that the need to care for others and be needed for this role can cause considerable difficulty. It can lead to making patients and colleagues dependent and cause you to be resentful of this dependency but to interfere when they try to become independent.

Depression may also result from a sense of powerlessness, but as nurse, you are actually far from it. You can decrease some of this sense of powerlessness by making yes/no decisions such as "Yes, I'll take that job that I know will really challenge me" or "No, I won't float to a unit where I'm a hazard". Recognize that you have needs and assume some control over your personal life. If you live alone, schedule yourself to go out a certain number of times per week. It is too easy to come home at the end of a long shift,

fall asleep and not do anything with your time. You feel fatigued all the time but unless there is something wrong physically, the problem is probably depression, which can be lifted or decreased by assuming some control over your life. If depression is really bad or persistent than it's time to seek outside help; remember nurses have needs too.

Dealing with anxiety and the inability to make decisions or think straight may also be related to a low sense of self-esteem and fear of failure or sometimes even, the fear of success. If you are having a lot of anxiety, sit down and try to figure out exactly what is happening. List the symptoms you are experiencing. Try to identify what causes the anxiety — is it that you fear being yelled at by a doctor, are you afraid you'll give the wrong drug, won't know how to do a procedure, may be in a position of telling a doctor what to do and being put down? Is your fear logical or illogical? If it is logical, such as being insecure working with a certain machine, then take the time to have it explained to you. Don't allow yourself to be put into a position where you are accountable for things you really don't understand — it's an issue of assuming power and responsibility again. If your fear is illogical, then try to figure out why it might have come about — is this a situation reminiscent of your childhood when your father consistently yelled at you? Are you afraid of confronting physicians with what might be superior knowledge fearing that they will think you are a castrating female? Talk to other nurses and find out how they handle these situations. Figure out how you can make valid suggestions in appropriate ways without playing the traditional doctor-nurse game.

The use of drugs to handle the stress of personal and professional life is an area of particular concern. The availability and liberal use of drugs in a hospital setting has resulted in a high addiction rate for nurses and doctors.



Using drugs to alleviate stress should be a last resort: explore other options such as a stress-management program, an assertiveness training workshop, changing your lifestyle to allow for more pleasure in your personal life and even changing jobs. When you use drugs, it should be under a doctor's order — that doesn't mean getting a prescription from your friendly resident. If problems persist, see a psychiatrist or other mental health professional for help in understanding the root of the problem rather than using chemicals to block it out indefinitely.

#### **The soma — taking care of yourself**

The signs and symptoms of physical problems which may or may not be related to psychological problems include:

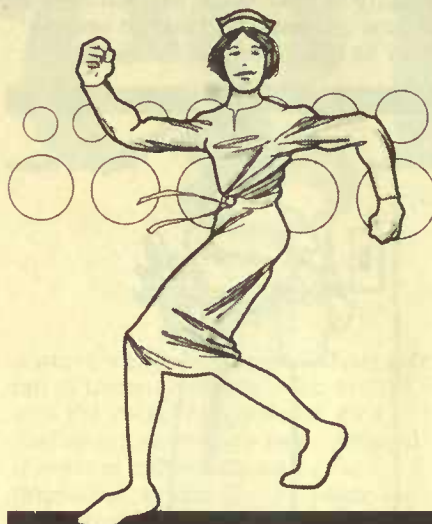
- chronic fatigue
- headache, stomach pains
- frequent colds and flu
- frequent somatic complaints of other types
- increased use of sick days.

If you are having a lot of physical problems then it is time to get a good physical examination from a competent physician who will take the time to really explore what is going on. Nurses seem to have a rather ambivalent relationship with the medical care system and tend to either over-doctor, going with each ache or pain or to under-doctor, believing that only "patients" have problems. If you are having numerous physical symptoms and are frequently at the doctor's office, it is time to ask yourself whether you are actually physically ill, whether you are under too much stress or whether constant exposure to various diseases has made you afraid you are developing cancer or heart disease. A well-balanced diet with an effective program of weight maintenance or reduction should be part of each nurse's self care. Regularly scheduled meals eaten in an unhurried fashion with the controlled use of xanthenes, cholesterol and unnecessary carbohydrates gives the energy necessary for work and play.

Avoiding regular physical exercise can be a reflection of a lack of interest in yourself. Taking care of everyone else at the expense of yourself is self-destructive. The minimal exercise you get often leads to overweight and a generalized sense of lethargy. Talking with people who successfully maintain a

stress reduction program one finds that they schedule time for walking, running, swimming, squash or some sort of regular exercise.

#### **Jogging, swimming or dancing**



A sure sign of an increasing stress level is frequently spending the night dreaming about your job or having dreams of powerlessness and anxiety. Shift work predisposes one to sleeping problems. Allow time for proper sleep and if you establish a chronic sleep deficit on night duty remember that it will stay with you for quite awhile before you get caught up.

#### **Family and social life: getting to know others**

Research has shown that social support is important in mediating the impact of a variety of life stressors; people need people. Overextending yourself with work oriented activities so there is no time to nurture the relationships at home is a common nursing problem. When you are at this point, you may find yourself in real trouble and you should sit down and assess your

## **Stressed? Or Burnt Out?**

*Marvel Miller Sanders*

Every day you arrive home exhausted, but you can't sleep. You resent your work, but it's always on your mind. You feel bitter. You're stagnating. Are you just under stress? or are you burnt out? The point at which stress becomes "burnout" is cloudy: in fact leading nursing researchers aren't even sure how to identify the condition. However, on two things they are agreed: burnout is stress gone out of control and all nurses are susceptible hosts. Read how the experts view the problem.

Nursing literature first began to comment on "burnout" in the early 1970's but it is only recently that much has been written on the issue. Herbert Freudenberger, a mental health co-ordinator at a New York clinic, coined the term "burnout" in the late 1960's when he recognized symptoms of exhaustion and fatigue in his dedicated staff of social workers. He noted weight loss, insomnia, depression, shortness of breath and physical deterioration among them and, in addition, they appeared bored, resentful, disenchanted, discouraged and confused.

Noting the same physical symptoms in nurses, Seymour Shubin, one of the first male nursing leaders to write about burnout, outlined some specific ways nurses manifest burnout. He observed that they were:

- spending as little time as possible with patients
- referring to them by symptoms
- going strictly "by the book" in administering treatment
- joking excessively about the patient or his ills.

Shubin believes that sometimes the converse can occur. Some nurses become too closely involved with patients, cannot turn off thoughts about their work after hours and begin to find excuses to stay on duty long after they have completed a shift. He says these behaviors can change a nurse's personality and she may begin to treat her relatives and family the same way she treats her patients and colleagues. Since nursing is emotionally taxing and demands optimum physical well being, the nurse who suffers the initial stages of exhaustion, psychosomatic illnesses such as colds and headaches, cannot survive the rigors of a full day in an active treatment setting. She will likely move



priorities. Look at what your real values in life are. For example, if your role as a wife and mother is primary, then you will have to get your work situation under control. This involves assessing why you are working so hard. Are you trying to be all things to all people — never saying no to anyone but seething and resenting things inside? Do you have a very strong need for praise?

(Patients are often much more grateful for services rendered than are families who have a way of expecting that you have an obligation to care for them.) Do you have a great need to be needed? You may be giving far more than is necessary, constantly trying to prove that you really are a good nurse, hence a good person. Having nothing left to give at home can then set up a situation in which you feel guilty, thus making you feel that you are not very good after all. Are you creating completely unrealistic demands on your family?

A good way of preserving family relationships is to get rid of job tension before you arrive home. A short walk or just time to yourself can help defuse some of the tension you feel. Dividing

I give at the office!



quickly to the stages of guilt, dislike of self, and then on to what Shubin calls the stage "where there is total disgust, a sour attitude towards humanity and self, resulting in terminal burnout".

Dr. Frances Storlie, one of the most recent nursing leaders to write on the topic, describes burnout as an "insidious process with an etiology which is difficult to trace". She believes that the most susceptible host is a highly idealistic young nurse. The process may begin while she is still a student, when learned ideals conflict with the real world of health care. This conflict can lead a nurse to a state of frenzied activity wherein she may become aggressive, charged with energy, taking on new tasks or working long overtime hours. "At the same time the nurse may become sensitive to the slightest criticism, perceiving non-existent depreciation in light or tangential remarks" says Storlie. "At some point in the frenzied search for reality, the nurse gives way to self doubts and self re-evaluation — this is the crucial point...the nurse either begins to recover or goes on to burnout."

Dr. Marlene Kramer, author of "Reality Shock", spent eight years researching the problem and came up with similar notes on burnout and its causes. She points out that in many young nurses, the discrepancy between what they learn in school and what is actually practiced in the work setting, results in "professional-bureaucratic work conflict". She says this conflict results in "reality shock", wherein the new graduate may experience rejection of her new surroundings or exhibit regression manifested by a pre-occupation with the past. Occasionally, there is a total rejection of the school-taught values, and the neophyte becomes a "super efficient bureaucratic technician". Other common reactions are feelings of failure, rejection of their formal professional education, withdrawal and moral outrage against the school which "failed to prepare them" for the job situation. These feelings of anger, hostility and frustration lead to fatigue and illness. The new graduate often does not recognize the problem and deludes herself into thinking that things will get better, or that somewhere there is a perfect job or work situation. This unfulfilled hope only generates continued frustration and despair, which escalates until burnout occurs.

Nurse educator Bernard Shapiro, claims overstated altruism is to blame for burnout suffered by nurses. While he believes altruism is a desirable characteristic in nurses, he says it is not sufficient to carry them through what he terms an "unbelievably difficult" career. Shapiro upholds that many nurses who leave the profession, do so because the altruism which started them on their career was not sufficient and that those "disenchanted nurses who remain assume an icy detachment, machine-like efficiency, or arrogant, patronizing airs."

In the view of nurse educator Estella Robinson, one could substitute the word "burnout" for "anxiety". Robinson labels the condition "patient-nurse alienation". She states that nurses are affected by society's alienating milieu

up family roles can also relieve you of the need to prove that you are "supermom, wife and nurse": share cooking, cleaning and child care responsibilities and schedule time for relaxing together. A casual dinner with a bottle of wine on a Friday night is a nice way to end a busy week.

Learn to listen to your family and get support from them. If they complain that there is not enough time for them, look carefully at what is going on. Are they afraid work is becoming too important to you or are they just asking you to be around a bit more? You should also realize that children can be proud of your career so let them know what you do and bring them to see where you work. When they understand what you do, they will be more accepting when you come home tired.

Friends can play a very influential role in your life as well. Building a good social support system and developing new relationships can lend a whole new richness to your life. It is important to note that social relationships can form an open or closed network. In a closed network, everyone knows each other. While helpful in daily activities, this kind of system can be restrictive. For example, research on bereavement has shown that women from closed social networks are assisted in adjusting to widowhood in the early days and months but if they want to branch out, make new friends and form a new identity, it is difficult because others are threatened when they begin to change. In an open network everyone doesn't know everyone else and an individual may be able to get different types of help from different people. If you do not have any openness within your own social network, try to branch out a bit and develop relationships with people outside of your usual family and professional sphere. Talking to other women can be a good experience because it makes you realize that what you are going through is not unique to you but is more likely part of a larger societal issue, one with which other women are grappling. An effective way of dealing with a stressful job can be having lots of friends who are not nurses. Such relationships are enriching and give you the potential to bring new energy and insights into your personal and professional life.



**Occupational life—putting it all to work**  
As nurses, we often fail to see ourselves as autonomous beings, rather we see ourselves as helpless victims, victims of our socialization as women, of our education as nurses, of the bureaucracy of the health care system and of power-plays by physicians. To operate from the position of helpless victim negates the strength we have when we decide to become assertive and unite, as witness the recent Alberta nurses strike. To be a helpless victim is in fact a power play, the power of the powerless may be somewhat subtle but it is there. It comes from our fear of accepting responsibility, of standing out, of daring to take risks. Look what happens to nurses who dare to be different, they often get put down, or put "back in their place" by other nurses who subtly or not too subtly give the message, "What makes you think you're competent to be doing or saying that?" "What makes you think you're better than I am?" The message is "you only succeed at my expense. Your success threatens my powerlessness."

Nurses are often ambivalent about learning from other nurses because we have a low sense of self-esteem as women and as members of a female profession, we tend to project our feelings of incompetence onto other nurses and figure that only male physicians can really teach us very much. In a recent evaluation of the instructors of a nursing program, students said, "we learned a lot from the doctors but you girls didn't teach us anything we didn't already know."

There are many put-downs we give to one another. Take for example what feminists call the "queen bee syndrome": that is, women who get ahead and then deny their roots and set themselves apart as being above other women. At a recent gathering of professionals from varied disciplines, two attractive professional women were present. The moderator introduced them as both having PhD degrees and sharing a similar background which they had forbidden him to mention. The two women were nurses. However the fact that they were attractive, held advanced degrees and had good careers—all qualities highly valued in the male-dominated system—gave them sufficient status to repudiate their original profession. The fact that each was in a position of evaluating health care facilities made their nursing

knowledge very valuable, but they chose to take what they wanted from nursing and leave. One woman said she refused to see herself as a nurse because as a nurse she felt put-down and powerless.

It's a tough life, being a nurse.



► especially because of increased technology and are often ill-prepared emotionally to cope with this alienation. She believes alienation results in stereotyped and rigid interpersonal behavior on the part of the nurse and this in turn produces self-alienation. Robinson concludes that alienation involves treating a patient in a mechanical manner and is used to protect the nurse from anxiety.

Although men in the health professions appear to suffer from burnout, there is a possibility that many nurses are experiencing symptoms mainly because they are women. Sexual discrimination and women's present complex role in our turbulent society places additional stress on them. In addition to the caring, giving and altruistic attitude towards clients, many nurses must also extend these same feelings to their husbands, children and perhaps aging parents and in-laws. According to Elaine Brody, this is especially true of the middle-aged nurse who is subject to a whole host of new expectations as well as the traditional filial responsibility of care of the elderly.

Rogers, a psychiatric nurse educator, claims that because nurses are predominately female, they are caught up in stereotyped role relationships with men, involving the issue of power and control. Sex roles in nursing have not yet changed to any extent since Rogers declared: "the status or position of the male in the health care hierarchy is usually higher than that of the female." This places an additional burden on nurses who may tend (perhaps unconsciously) to court the favor of these males in order to gain access to power. They are condoned and encouraged in this behavior by male physicians and administrators and the game of sexual politics continues.

Alice Baumgart, a leading Canadian nurse educator, feels that sexist attitudes are hampering the struggle for professionalism. She states "The interest, the knowledge, the academic aspiration of women have been devalued when measured against those of men. The same ability, the same expertise, the same performance has been more highly valued in men than in women."

These sexist attitudes may well extend beyond the nurse's professional life. Her social life and home atmosphere may also place her in positions where she must continue to exhibit passive-aggressive behavior. The giving, caring nurse may well find this behavior only adds to her disillusionment and bitterness and that it precipitates or aggravates burnout.

Burnout is almost impossible to define and its etiology is obscure. Whether nurses exhibit symptoms because they are too idealistic, too dedicated, too altruistic, or conversely because they may lack career commitment is difficult to determine. Perhaps the major factors are the working conditions combined with heavy home responsibilities and sometimes academic pressures as well. Regardless of cause, burnout results in unprofessional behavior, dehumanization of patients, and an exit of women from nursing.

Nursing is losing good people to other careers because of the feeling of powerlessness they experience. The whole concept of power needs to be reassessed. Power should not be seen in terms of the male-oriented dominance/submission, controller/controlled model but rather from a more female perspective as a process of effecting change. Be aware of the ways in which you respond to the power of others who attempt to control you: remember you cannot be governed by another unless you choose to follow or be controlled by that person. Take for example the case of Alberta nurses who refused to accept the government's pay offer. The nurses found that the government was shocked that these nice, caring people would not accept the salary the omnipotent male-dominated government had decided was appropriate. However, they united and succeeded in getting improved wages. Nurses do need to unite to effect the changes that are necessary. Think through what you try to change and be careful of what you ask for — you might get it.



To effect greater change, nursing needs an organized system to create leadership roles and to encourage other nurses to move ahead. In the past, nursing leaders picked out those neophyte nurses they thought had strong potential and provided encouragement, role-modelling and introductions to other nursing leaders. However such a system no longer exists and many nurses are finding themselves in dead-end roles. Nurses need to give praise to one another and help each other to feel tall. A new nurse on an intensive care unit was thrilled when she handled a difficult situation and two of her peers looked at each other and said, "She did a good job. She belongs."

As nurses, we obviously have difficulty coping with our own interpersonal difficulties but what about our relationships with other disciplines? A sense of self-esteem is essential. If you are competent and do not consider yourself to be a handmaiden, then you will not be treated as such. Often put-downs are interpreted from others when they do not necessarily exist.

Some nurses are seeing themselves as very competent and are assuming expanded roles quietly in the background. When others, such as doctors, social workers or psychologists,



Member of the team

Many factors contribute to burnout among nurses and, as yet, only a few solutions are being applied. Nursing leaders must realistically examine the "burnout phenomenon" as a possible source of a poor quality of patient care and a very probable influence on increased costs of health care in our country. Researchers could develop a tool such as a questionnaire or rating scale which would detect and measure burnout in nurses. Is there a correlation between our universal health care system and burnout? Can burnout be predicted? If so, should "high risk nurses" be assigned to intensive care units, terminal care areas, burn units? Ethical issues need to be examined too. If a co-worker exhibits or confesses to symptoms of burnout, yet refuses to rectify the situation, how should this be handled?

Burnout must not become a casual "wastebasket" term for every and any difficulty a nurse may be experiencing, the "status illness" of our profession. But, at the same time, we cannot afford to allow the burnout syndrome to flourish unchecked. We owe it to ourselves and our colleagues to recognize and deal with this issue.

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eventually realize how competent the nurse is they can be very threatened and seek to eliminate the expanded role she has assumed. They attempt to clearly delineate roles and prevent role-blurring. But we have gone too far for this. Nurses are going to have some rough roads ahead as we struggle for expanded roles. Belonging to multidisciplinary groups such as a palliative care work group and/or attending multidisciplinary meetings where the focus is on the broader subject rather than on turf fights about Mrs. Jones can be a useful way to deal with such problems. Sometimes when you establish credibility by working together with people outside of the immediate patient care setting, the good will which evolves is carried back to the clinical setting and facilitates day-to-day communication.

Our history as women has functioned to make us feel fairly powerless within the health care system. Much of the powerlessness is a myth. As more nurses develop an increased sense of self-esteem and autonomy, it will be possible to make the changes necessary to bring us into the twenty-first century. These changes must start with one's self. Coping with the stress of life through improved attention to your physical and psychological health, building outside support systems and strengthening relationships within the profession can help you meet the challenge of the changes of the future. ♡

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## MOTOR CYCLIST HOSPITALIZED AFTER COLLISION

## SIX-YEAR-OLD SUFFERS HEAD INJURIES IN FALL FROM BALCONY

## WINDOW WASHER SUFFERS CONCUSSION WHEN LADDER BREAKS

What do you know about assessing possible increased intracranial pressure? Could you give comprehensive care to these accident victims? Here's a guide that may help.

# Increased intracranial pressure: when assessment counts

Angela Ladyschewsky

### Why does it happen?

The causes of increased intracranial pressure are numerous and relate to an increase in one of the three basic cranial components within the rigid, unyielding structure of the skull. The space required by these three components—brain tissue, blood and cerebrospinal fluid—is dependent upon some of the following conditions:

**Brain tissue** may increase in volume because of: an increase in cell growth as in tumor formation; hypoxia, as inadequate brain perfusion results in sodium remaining within the cell and drawing extra fluid in to increase cell size eventually leading to cell rupture, closed head injuries (contusions) with generalized cerebral edema; and intrusion by foreign objects.

The volume required by the **blood component** may increase with vasodilation. This occurs with hypoxia as increasing levels of carbon dioxide ( $\text{CO}_2$ ) and hydrogen cause the veins to dilate, especially those in cerebral tissue.<sup>1</sup> As well, damaged cells excrete histamines, bradykinins and potassium which are all powerful vasodilators. Arterial/venous malformations such as aneurysms or hemorrhages within the cranium also increase space demands.

**The cerebrospinal fluid (CSF) component** may increase for one of three reasons. First there may be an increased production of CSF due to rare choroid plexus papillomas. Normally 50 per cent of the CSF is formed in the choroid plexus, a highly vascularized structure located in the walls of the lateral and third and fourth ventricles.<sup>2</sup> Secondly, there may be a decrease in the rate of absorption of CSF by the arachnoid villi, small venous indentations of the arachnoid membrane. This may be due to blockage of the arachnoid villi by blood from birth trauma or a spontaneous subarachnoid hemorrhage.

Finally, there may be interference with the circulation of CSF due to tumors, adhesions, congenital malformations of CSF pathways, arterial/venous malformations, hemorrhages or infection.

If ICP increases to a point where there is no more room for expansion within the skull, the cranial contents are pushed downwards in a process known as "coning". The end result is transtentorial herniation, that is, the brainstem and part of the cerebral hemispheres are pushed down through the tentorium (*See figure one*). Compression of this vital center, the brainstem, accounts for decreased levels of consciousness, pupil changes and changes in pulse and respiratory rate.

### Observations for suspected increased ICP

1) Upon admission after establishing that ventilation and circulation are adequate, obtain enough information to establish a baseline of data. This would include the normal information accumulated in the admission nursing history as well as details on the type of accident or precipitating conditions, of any loss of consciousness, of any previous consumption of alcohol or medications (this will affect consciousness levels and pupillary response) and any previous neurologic deficits, such as paresis, speech disorders, deafness, etc.

Early signs of rising ICP may be noted at this time and include: restlessness, irritability, confusion, disorientation or a decreasing level of consciousness due to cerebral hypoxia, headaches, either constant or increasing in intensity, which are aggravated by coughing, sneezing, straining, etc. and nausea and/or vomiting due to pressure on the vomiting center in the medulla oblongata.

2) Determine the level of consciousness. Is the patient alert? If so, is he oriented to time, place and person? What is his

attention span? Is he drowsy or lethargic? Does he respond to painful stimuli in a purposeful way, that is, does he push the pain source away?

The most important indicator of cerebral functioning, that is, consciousness, is controlled by the reticular activating system in the frontal lobe.

Levels of consciousness include:

- alert: responds appropriately to auditory, tactile and visual stimuli, is oriented to time, place and person,
  - lethargic: sleeping much of the time but is easily aroused and is oriented,
  - obtunded: is difficult to arouse from sleep, responds appropriately when awake, but returns to sleeping state quickly when stimulation is discontinued.
  - stuporous: arousal only by painful stimuli, response to stimuli is purposeful but the individual is actually never fully awakened (painful stimuli may be applied by pressing your fingernail into the patient's nailbed, applying a sternal rub or pinching over the Achilles tendon).
  - semicomatose: painful stimuli elicits reflex movement, decorticate posturing or decerebrate posturing and corneal and gag reflexes are present. The corneal reflex, with its nuclei situated in the pons, may be checked by touching the cornea with a piece of cotton. An immediate blink indicates an intact reflex. The gag or pharyngeal reflex with its nuclei in the medulla, is tested by holding the tongue down with a depressor and touching the pharynx with a cotton tipped applicator. Presence of a gag indicates an intact reflex.
  - comatose: no response to painful stimuli, reflexes are absent and there is no muscle tone in the extremities. Remember, that description of the level of consciousness is more helpful than a label used inaccurately.
- 3) Once the patient is as alert as possible,



motor responses, muscle strength and function controlled by the pyramidal tracts, should be assessed. Does the patient move his extremities to command? Is there any weakness and if so to what degree, for example, is one limb slightly weaker or noticeably weaker than the other? Don't always rely on testing the patient's hand grips for strength: check for arm drift. Ask the individual to lift both arms in the air and close his eyes. Watch for drifting downwards of either arm, thus indicating weakness.

located in the midbrain. Are the pupils equal in size or do they differ? What is their size, that is, are they constricted, normal or dilated? What is their reaction to light, do they react sluggishly, briskly, normally or is there no reaction at all?

Under optimal conditions, pupils should be examined in a darkened room. Cover the eye not to be examined and pass the light source over the eye from the outside to the inside. Remember that miotic and mydriatic medications affect pupillary reaction to light.

pressure is indicated on the midbrain and upper pons where the nuclei for the third, fourth and sixth cranial nerves are located.

5) Vital signs should be checked at regular intervals from every 15 minutes to four times daily, depending on the patient's condition. Observe for any fluctuations or changes. While a quickening pulse and a dropping blood pressure are signs of hemorrhage, the very opposite is indicative of increased ICP. The medulla responds to increased pressure on the brainstem or decreasing

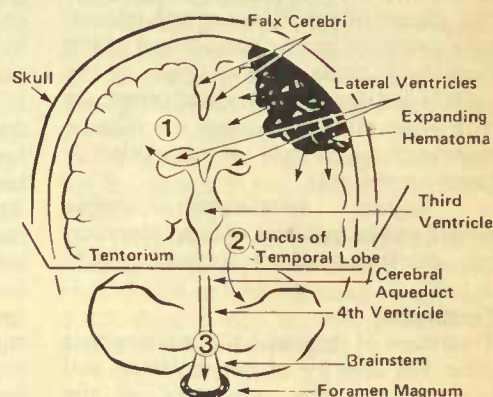
**Figure one: Stages of Transtentorial Herniation**

1. As ICP increases, as from an expanding hematoma, there is a midline shift of the falx. The lateral ventricles are pushed over and compressed. Fluid from the ventricles is squeezed out into the intracellular spaces.
2. As the ICP continues to rise, the brain content is pushed downward, the only escape being through the tentorium. The uncus, the hooked edge of the temporal lobe, herniates.
3. As the pressure continues to increase, the cranial contents are further displaced downward. The only direction being toward the foramen magnum. The medulla — brainstem become compressed.

There are two other types of herniations. They are:

- A. Supratentorial (above the tentorium)
- B. Subtentorial (below the tentorium)

NB. The tentorium and falx are folds of meningeal dura. The falx is attached above the tentorium and forms a roof over it.



If the patient is ambulatory, have him walk, observing his gait; an unsteady, ataxic gait may indicate cerebellar dysfunction. Movement of arms, fingers and toes should also be assessed.

If the patient is unable to follow verbal instructions, voluntary movements must be noted whenever they occur. When even voluntary movement is absent, purposeful movement with stimulation must be assessed. Check the Babinski reflex by moving an object up the lateral side of the foot. A negative Babinski, plantar flexion of the great toe, is a normal reaction.

Stimulation may elicit decorticate or decerebrate posturing. Decorticate posturing, which indicates damage to the internal capsule and corticospinal tracts above the brain stem, is recognizable as fingers, wrists and shoulders are flexed and adducted while the feet and legs are extended and internally rotated, all extremities are rigid. Decerebrate posturing, indicating mid-brain damage, includes extension, adduction and internal rotation of the arms, extension of the legs with feet in plantar flexion and arching of the back, with all extremities again being rigid. 4) Observe pupil size. Reaction to light and extraocular movements are important indicators of increased ICP as the third and fourth cranial nerves are

To check for consensual light reflex, both eyes are held open wide, a light is shone in one eye and the reaction in the other is noted. If consensual reaction is present, the opposite pupil will constrict and indicates that optic fibers which diverge in the mid-brain are intact. Pressure on these fibers which form the oculomotor nerve can be identified by unilateral pupil dilation, ptosis and decreased eye movement. Interruption of sympathetic pathways from the pons causes the pupils to be constricted and non-reactive.

Next, check eye movement by having the individual follow your finger without moving his head. Movement up, down and to both sides should be assessed as well as conjugate eye movement (eyes move in the same direction at the same time), doll's eye maneuver and clarity of vision, including blurring and diplopia. The doll's eye or oculocephalic reflex, a normal reflex that can be controlled by the conscious individual may be tested on an unconscious patient. While holding both eyes open, move the head from side to side and check the eye movement. Normally both eyes will turn in the opposite direction of the head movement, that is, if the head is turned to the right the eyes should turn to the left. If the eyes remain fixed in the midline position, or movement is disconjugate, then

circulation to the cerebral tissue by causing the pulse to decrease and the blood pressure to increase. However these are both late signs of the problem, indicating sustained pressure peaks of ICP.

The patient's respiratory status should be assessed with consideration to both rhythm and depth of respiration, both of which are controlled from various positions within the brainstem. Look for snoring and irregular breathing, both signs of pressure and resulting anoxia of the respiratory center in the medulla. Some typical respiratory patterns which may be identified include:

- apneustic breathing which indicates brainstem damage and is identified by a typical abnormal rhythm of holding a breath for a long period and then letting it out at a regular rate.
- Cheyne-Stokes respirations, considered a late sign, are recognizable by their long, hyperpneic phase followed by a shorter phase of apnea. This type of respiration indicates pressure on or an interruption of the descending motor tracts at the mid-brain level and occurs as a result of an increased sensitivity to CO<sub>2</sub> causing the period of rapid deep breathing to rid the system of CO<sub>2</sub>. When this is accomplished and the CO<sub>2</sub> stimulus is no longer present, respirations are



discontinued until another build-up of CO<sub>2</sub> stimulates respirations again.

- central neurogenic hyperventilation, continuous, regular, rapid and deep hyperpnea is caused by anoxia of the midbrain and pons. If the pneumatic center in the pons which controls the rhythmicity of respiration is affected, respirations may become irregular with several deep gasps followed by an apneic period and repeated as in Cheyne-Stokes.
- clusters of breaths followed by apnea may result from damage or pressure on the upper medulla oblongata which contains the respiratory center.

When observing any of these types of respirations it is of utmost importance to identify if respirations are regular. If not, record the duration of the inspiratory phase, of apneic periods and of the expiratory phase and, as well, if the pattern is consistent or intermittent. As it is often difficult to label the type of respiration accurately a description is usually preferable.

Regular temperature checks should not be overlooked as an elevation can be indicative of increasing ICP.

### Treatment

Treatment of increased ICP is dependent upon the severity of the condition and may include one or several of the following.

1) Osmotic diuretics, such as Mannitol, are only a short term treatment. Given intravenously, as a drip or a bolus, Mannitol acts by increasing the osmolality of the blood to create an osmotic gradient and thereby draw fluid from the brain cells into the vascular system. Effective for only three to ten hours, be aware that a rebound effect may occur if this type of medication is used over a prolonged period. Mannitol can enter the cerebral tissue and cause a fluid shift into the brain tissue creating a further increase in ICP. The usual adult dosage is 100 g daily, never exceed 200 g/24 hour period. In bolus form 40-50 g may be administered.

Prior to administering this type of medication, a Foley catheter should be inserted so that urinary output may be closely monitored. After administration, observe carefully for any signs of vascular or cardiac overload such as pulmonary edema, or congestive heart failure; electrolyte imbalance, especially a depletion of sodium or potassium, and dehydration.

2) Steroids, most commonly Dexamethasone (Decadron®), is used to act as an anti-inflammatory agent and as a diuretic. The initial dose of dexamethasone is 10 mg followed by 4 mg every 6 hours, usually intravenously. Maximum effect is normally noted after 12 hours, but the drug may be used on a long term basis for a period of weeks. Side effects include all those common to steroid administration, ie. gastro-

intestinal bleeding, suppression of infection, retention of sodium, aggravation of diabetes, etc.

3) Fluid restriction is commonly practiced to avoid contributing to cerebral edema although it is of little value in reducing ICP. A daily maximum of 1500 cc either intravenously or orally is a realistic level.

4) Hyperventilation may be used to decrease CO<sub>2</sub> levels as the volume of cerebral blood flow is directly proportional to the plasma CO<sub>2</sub> level. Intubation with an endotracheal tube and use of mechanical ventilation can produce a cerebral decompression rapidly but blood gases must be evaluated frequently to ensure stabilization of arterial CO<sub>2</sub> levels.

5) Barbiturates, such as thiopental or pentobarbital, may be used along with ICP monitoring and hypothermia to treat increased ICP when the cause is known not to be a hemorrhage or post-operatively if a repair has been done. Barbiturates are thought to decrease the demands of the cerebral tissue for oxygen, thus decreasing the blood flow to the brain, or to have some specific action on the vascular tone of the cerebral vessels, causing them to constrict thereby reducing blood flow to an already edematous brain.<sup>3</sup>

Usually barbiturates are administered on an hourly basis to maintain a blood level of 3 mg/100 ml of blood. ICP is monitored through the use of a screw or bolt inserted into the subarachnoid space through a burr hole and connected to a transducer which transcribes pressure changes to a graph.

6) Surgery, including removal of a localized hematoma or tumor, insertion of a ventric drain into one of the lateral ventricles, or removal of a bone flap to allow for expansion may be utilized. The opportunity for severe herniation of the brain tissue through the surgical opening may make this a risky procedure.

### Nursing priorities

There are many things that you can do to ensure that your patient will not succumb to the effects of increased ICP.

First, be aware of the importance of a clear airway. Since increased CO<sub>2</sub> concentrations cause cerebral vasodilation, any factor that may cause your patient to hypoventilate must be eliminated. Work to prevent chest conditions such as pneumonia or atelectasis from developing. Listen to chest sounds regularly. Use narcotics cautiously as they depress respirations. Position patients on their sides if consciousness is decreased to prevent aspiration. Encourage those who are alert to deep breathe and encourage positioning which is conducive to maximum ventilation. Coughing and sneezing must be

prevented as much as possible.

Second, keep an accurate record of intake and output. Restrict fluids as necessary and monitor all intravenous infusions closely. Patients on Mannitol should have a fluid intake of 2500 cc daily to prevent dehydration. Observe for electrolyte imbalances, indicated by serum values, changes in behavior, decrease of urine specific gravity below 1.010, muscle weakness and diminished reflexes.

Third, elevate the head of the patient's bed to 30 degrees to promote increased cerebral venous drainage through use of gravity. Avoid neck flexion and having the head higher than 30° as a negative pressure may be created and force intracranial contents downwards towards the foramen magnum.

Fourth, reduce straining by your patient through the use of stool softeners and mild laxatives to prevent constipation and straining at stools (never give an enema). Administer antiemetics to reduce vomiting and nausea as necessary. Instruct your patient not to use the Valsalva Maneuver which occurs when the patient strains while defecating or trying to move himself up in bed, using his upper trunk muscles. As the patient holds his breath, the upper thorax becomes fixed, the breath is forced up against the glottis and the thoracic pressure as well as the intracranial pressure is increased. When moving up in bed, instruct your patient to exhale. Do not restrain your patient unless absolutely necessary as fighting with restraints increases physical activity and need for oxygen. If your patient requires suctioning for increased secretions, do so for 15 second periods only, and hyperventilate with oxygen first.

Fifth, be aware of the importance of rising temperature. Patients may experience an increase in temperature due to interference with heat regulating centers in the thalamus. "For each one degree centigrade rise in body temperature the body tissues' oxygen requirements increase by approximately 13 per cent."<sup>4</sup> If the temperature is elevated, remove excess blankets, give tepid sponge baths, use fans, reduce the room temperature and give antipyretics as ordered.

Finally, observe for seizures which may occur as a result of cerebral irritation. Naturally establishing an airway is of prime importance, but observation of all aspects of the seizure including muscle groups involved is necessary for identifying the focus of the problem. If an individual is seizing with his mouth clamped tightly shut, no attempt should be made to force it open as this will only result in damage to oral tissues and teeth. Instead, simply position the individual on his side to facilitate



drainage of secretions. Remember that any seizure lasting longer than four to five minutes is a medical emergency (status epilepticus) which can lead to severe cerebral hypoxia and respiratory arrest.

All individuals suspected of having a head injury are candidates for seizures. Keep an airway at the bedside, use a night light, use only rectal thermometers, keep side rails in place, have a suction machine available and give anticonvulsant medications on time.✶

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\*Not verified

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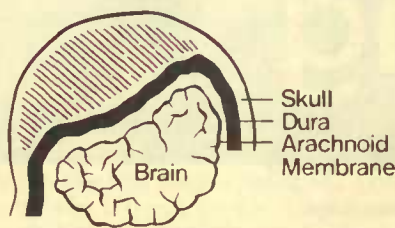
# TYPES OF CEREBRAL HEMORRHAGE

**1. Epidural hemorrhages** occur most commonly as the result of a laceration of the middle meningeal artery in the temporal lobe. The temporal portion of the skull is thin and thus very fragile, consequently blows to this area are dangerous and frequently constitute a surgical emergency. Although the rapid escape of blood between the dura and the skull causes intracranial pressure to rise quickly, the prognosis is usually good if treatment is initiated early. Rupture of the middle meningeal artery results in an inward pressure on the temporal lobe with ipsilateral pupil dilation resulting from compression of parasympathetic fibers of the oculomotor nerve, unconsciousness due to compression of the reticular activating system and weakness or paralysis due to compression of cerebral peduncles.

When this type of hemorrhage occurs in the posterior fossa, it is frequently fatal as the lack of local signs coupled with depression of the cardiovascular center and reticular activation system make detection early enough for treatment almost impossible.

In the subfrontal area, an epidural hematoma may be indicated by headache, bilateral retro-orbital pain, intermittent disorientation, poor recent memory recall and papilloedema.

Treatment involves a craniotomy to facilitate removal of the clot formation as early as possible.



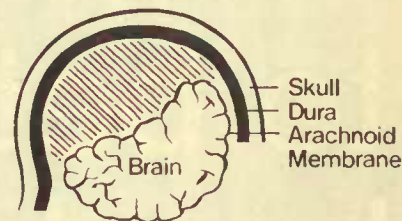
**2. Subdural hemorrhages** occur when bleeding takes place into the potential space between the dura and arachnoid membrane layers of the brain. Pressure is generalized over a whole hemisphere as movement of blood is limited only by the falx and tentorium. Symptoms of headache, loss of consciousness, pupil changes, personality changes and mental deterioration may be intermittent, depending on the type of hemorrhage:

**acute**, symptoms occur within 24 hours, there is rapid intracranial compression, prognosis is poor.

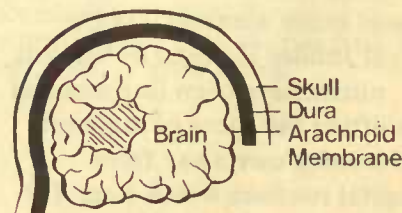
**subacute**, with a mortality rate of 25 per cent, symptoms occur up to one to two weeks after injury and is often due to laceration of cerebral surfaces and sinuses or both.

**chronic**, the least dangerous, may not be detected for weeks to months after the injury.

Treatment consists of surgical removal of the clot. A chronic CSF leak, an infection or brain abscess may ensue if the dura is not securely sutured to ensure that it is watertight.



**3. Intracerebral hemorrhages** occur when there is bleeding deep into the brain tissue itself. Petechial type hemorrhages are common and are often related to blood dyscrasias or superficial contusions of the brain. Symptoms are similar to those of a subdural hematoma but as yet surgical results are poor due to irreversible brain damage caused by the hematoma.







# Six steps to better bonding

Maternal-infant bonding is as old as mother love! In fact, that is precisely what it is and promoting a healthy maternal-infant bond should come naturally. At the Royal Jubilee Hospital in Victoria, BC, nurses have been instrumental in shifting the focus of maternity and nursing care away from hospital routines which were, for the most part, cold and intimidating to the more personal rhythms of mother and baby.

*Margaret Rhone*

The concept  
Maternal-infant bonding begins as early as the first fetal movement; it is an unfolding relationship in which the mother 'falls in love' with her baby. The process is not, however, one-sided: both mother and infant play an active part in the bonding process. The mother's behavior, derived from her own complex history of interpersonal relationships, her experience during pregnancy, labor and delivery, as well as her recollections from childhood, is dictated largely by her own self-concept and the positive or negative feelings she has about herself. The infant's role in attachment is based on his response to the mother, the response he elicits from her (determined partly by his own appearance), his sensory and motor ability and his sucking behavior.

Bonding is a fragile and protracted process: while it is taking place it can be disturbed or even broken and it may take weeks, months or even years for the union to solidify.

## Assessment

As nurses, we can use the tool of assessment to define the mother-infant relationship as either normal or maladaptive and then attempt to either enhance a healthy relationship or to intervene in a maladaptive relationship that could lead to later child abuse, infantile autism or other psycho-social problems in the growing child.<sup>1</sup> In assessing this interaction between mother and infant, the nurse looks at four stages in the mother's development:



*1. Preconception.* A medical and social history of the prospective mother plays a major role in this area of the assessment. How is the mother's general health? Does she have any physical incapacities, such as deafness or chronic illness, with which she must cope? How does she do this? Does she have anyone who is a significant mother-model, perhaps a favorite aunt? What can she tell you about the model's parenting style? Was her mother warm and loving or was she herself a victim of child abuse? What type of relationship does she have with her mate?

The answers to these and other questions may point to trouble ahead for the mother. Emotional and physical energy reserves are necessary for the development of a healthy mother-child relationship. Past experience with other mothers' parenting styles and the woman's own experiences as a child are often reflected in her parenting attitudes and activities; research has shown that victims of child abuse are at high risk for abusing their own children. Also a recent loss in the form of a divorce or death may drain a mother's emotions leaving her without the energy to form a new relationship with her new baby. She will also be especially susceptible to postpartum depression and its inherent bonding problems. A stressful family relocation to a new city or a change in employment status are just two of a number of other factors which affect a woman's attitudes towards pregnancy and motherhood.

*2. Present Pregnancy.* The pregnant woman is in the process of great change; things will never be quite the same for her. During this dynamic period her old role will be mourned and the expectant mother will accept and prepare herself for her new role, both internally, by becoming ready to accept change, and externally, by way of support systems. She will seek out other pregnant women, attend prenatal classes and obtain information on parenting through reading, discussing with friends and experts and observing her mother-model.

Activities such as changing her habits of eating and sleeping, seeing her physician, buying maternity clothes, seeking out other pregnant women and expressing joy over the 'kicking' movements of her unborn child indicate that she is validating her pregnancy and feeling positive about it. When the child is unwanted (this is not synonymous with unplanned), the mother does not prepare for his arrival, may not seek antenatal care, often will not choose a name and may even view the unborn infant's movements as threatening. One mother, abused as a child, felt that the baby was 'bruising' her.

*3. Parturition.* The bonding process may be dramatically affected by the actual labor and delivery. If the labor is short, that is, less than five hours, the mother may have some difficulty in realizing that the baby is here and is hers. If the labor is long and difficult, the mother feels only exhaustion when the baby is born. Her lack of enthusiasm over her newborn baby should not be assessed as abnormal.

If the mother's expectations of this period were exceptionally high during pregnancy, that is, if she were keen on natural childbirth without medication or assistance, she may feel bitterly disappointed if medical or surgical intervention is necessary. She may perceive herself as having failed and thus being a 'bad' mother, leading to feelings of guilt and consequent interference with the bonding process. Analgesics and barbiturates which pass the placental barrier also affect bonding. The mother who receives these drugs during the first stage of labor will have a baby who is sleepy for the first 48 hours of his life and she also will be groggy and perhaps even too tired to hold the baby immediately after birth.

*4. Early child-bearing stage.* Bonding during this stage can be initially assessed during the fourth stage of labor beginning with the birth of the baby. Immediate acceptance or rejection of the baby by the mother may depend on her preconceived ideas of what he will look like; there is the "fantasy" child and here is the "real" child. The normal mother stares at her baby in order to dispel her fantasy whereas the vulnerable child will have a mother who detaches herself from him, one who refuses to accept this "real" child. Illness,

deformity or prematurity often result in this stepping back or detachment by the mother and less than adequate bonding may be anticipated for any infant who requires extensive hospitalization after birth.

As the dream child gives way to the real child, the mother strives to discover what the baby is like. His behavior transmits a message to his mother, so that she will think "he's rejecting me — I'm not a good mother" or "he's okay, so I'm doing okay". The baby is an active partner in mother-infant bonding but not every baby is born wide awake, cuddly and content. The baby may be sleepy because of sedation received by the mother during a long labor or he may be irritable or jittery from a low blood sugar, jaundice or application of forceps.

How does the mother respond to the baby's cry? Is she able to distinguish the cry of hunger from the cry of pain, fatigue or boredom? Can she offer the appropriate response? A mother sensitive to her baby's cues will offer him the breast, reduce distractions, stimulate him with a toy or a song or provide another appropriate response. An insensitive mother will be angered, ignore the baby completely or perhaps even strike him.

Each baby, because he is an individual, has his own sensitivity threshold. A baby with a low sensory threshold is easily disturbed by loud noises and bright lights. He needs and responds best to soft sounds and lights, gentle handling and cuddling; he needs to be protected from too much stimulation. In contrast, a baby with a high sensory threshold is very sleepy. Because he initiates little interaction, he may receive a minimum of stimulation as he simply does not demand to be noticed and runs the risk of being ignored. He needs stimulation or he will not meet his potential. Parents of autistic children often describe them, in retrospect, as 'good' babies.



### Enhancing the mother-infant relationship

Ideally, pregnancy is a time of personal growth, readying the woman to provide loving care to her infant. The symbiotic relationship the mother has with her baby is momentarily broken at birth and must be re-established and maintained. At this time, some mothers need assistance in learning to gratify their infants so that they *both* can feel pleasure.

A healthy baby should be delivered straight into his mother's arms where he can be caressed and cooed at the breast. The parents and the new baby should then be left alone for the first hour, so that mother and father can get to know their baby on their own. Now the fantasy-child image is dispelled and the real baby takes his place. The baby during this first hour after birth is in a state of quiet

wakefulness; he then falls into a deep and peaceful sleep which usually lasts for three to four hours. Mothers who have been separated from their babies at birth have said, when reunited, that they didn't feel the baby was totally theirs. In leaving the baby alone with his parents for the first hour after birth, the unspoken message to the parents is "You are the important ones."

The early days after birth should be a time of mutual acquaintance for parents and baby. This is the time mother learns about baby's rhythms and needs and baby learns about how his mother will respond to him. 'Rooming in' facilitates this process. Studies have shown that mothers who have experienced 'rooming in' feel more confident and competent in caring for their babies than mothers separated from their babies in traditional hospital practice.<sup>2</sup>

As the new mother may feel sad and worried when separated from her children at home and this may be a source of emotional fatigue, all members of the family should be permitted to visit often.

**Intervention in maladaptive relationships**  
In order to promote a healthy relationship between mother and infant it is essential to assist each mother in realizing that each infant is different. This focus on individuality is essential.

The nurse plays an important role in helping the mother identify the unique traits of her infant, beginning with an understanding of his sensory level. With this knowledge the mother can then learn how she can best stimulate him in his emotional and cognitive development. Just as each baby has his own biorhythms and sensitivity level, each mother has her own personality characteristics: if the mother is impulsive, she may not consider the emotional needs of her infant, if she has a low capacity for empathy she may be emotionally isolated from her baby, or an independent woman may not be able to accept the role of being depended upon.

### ASSESSMENT OF MOTHER-INFANT INTERACTION DURING FOURTH STAGE OF LABOUR

Client's Name:- \_\_\_\_\_

#### A. Immediately after birth

-2-

-1-

-0-

Displays body movements in an effort to gain visual contact with baby. Asks about baby's condition, sex, appearance.

No visual contact attempted. Asks doctor, husband or nurse about baby.

Verbalizes concern for self. Seeks support for self. No questions about baby.

#### B. Few minutes later

Calls baby by name, affectionate terms or by appropriate sex.

Calls baby "it" or by opposite sex.

Does not speak to baby.

Expresses joy and/or satisfaction with the outcome of labour.

Expresses no feelings about outcome of labour.

Expresses dissatisfaction or anger at outcome of labour.

Holds by "en face" position and makes eye-to-eye contact.

Holds baby, no eye-to-eye contact.

Refuses to hold baby.

Reaches out to baby with fingers and looks at baby.

Glances at baby without reaching out or touching.

Does not touch or look towards baby.

Total Score \_\_\_\_\_ Time after birth \_\_\_\_\_ min. \_\_\_\_\_ hrs.

Score of 7-10 requires usual nursing support.  
5-7 requires extra nursing support.  
0-5 requires intensive nursing support.

Other observations of mother/baby that may affect above score:

Stressful labour? \_\_\_\_\_

Analgesics? \_\_\_\_\_

Caesarian section? etc. \_\_\_\_\_

(Source: Adapted from Grace Hospital, Calgary, "Parent-Infant Interaction Study," 1978. Mimeo.)



The primary concern of any obstetrical nurse must be this reuniting of mother and baby in a healthy symbiotic relationship. Interventions in maladaptive relationships must come between the mother and the difficulty she is experiencing, freeing her from a defeating pattern so that she may love her baby.

Six types of interventions<sup>3</sup> have worked for us at the Royal Jubilee Hospital. These may be grouped into two categories *enabling* or *directive* as follows:

• **Enabling**

1. **support:** words and actions which affirm the value of the person and show respect form the basis for all other interventions.

*Comment: We accept each mother for what she is, with her own personality, feelings and needs.*

2. **clarification:** words and actions which promote exploration and clarification of ideas, feelings and situations.

*Comment: We try to help the mother see her strengths and her fears and thereby herself.*

3. **catharsis:** words and actions which enable a person to discharge or gain release from painful emotions.

*Comment: We can help a mother free herself from restrictive emotions or feelings. Perhaps she has lost self-control during labor and delivery and now feels extremely embarrassed or guilty; this restrictive emotion may prevent her from loving her baby. The helper repeats the key words identifying the emotion.*

• **Directive**

4. **instruction.** giving information, new knowledge or teaching "how to" do something, for example, teaching a person to relax.

*Comment: The nurse should keep in mind that there are many ways of doing the same thing, for example, putting a diaper on a baby. The mother folds them her own way — this is not wrong. Show mother only if she asks you, or is having difficulty with a procedure, then let her practice doing it.*

5. **prescription:** giving opinions or advice; directing a person what to do or not to do; stating rules.

*Comment: Mother is free to accept or reject advice. Do not "take over" for her.*

6. **confrontation.** giving direct feedback; challenging the behavior/belief/attitude of the person.

*Comment: This is probably a very rare intervention. An example could be a mother rejecting her baby because he looks like her mother-in-law. The nurse's confrontation could be "You have trouble loving the baby because he looks like someone you do not like."*

**Conclusion**

The practice on maternity units of separating mother from baby at birth except during hospital-designated feeding times did not reflect what we know now about bonding. The mother was made to feel helpless and inadequate, she was discharged with a baby she hardly knew. Some mothers in this situation never fell in love with their babies.

Now, our primary concern in hospital is to "reunite" mother and baby in a healthy symbiotic relationship. The purpose of our interaction is to free the mother to love her baby so that they both will grow to their emotional potential. Our nursing goal is to enhance the mother and infant attachment so that the needs of both are defined and met and, in this way, the infant has the opportunity to develop as a healthy human being. ♡

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# New baby in the family

A nursing role in the preparation of children for the arrival of siblings

*Joy Bliss*

When a birth occurs in a family, many children are not psychologically prepared to move over and share the spotlight with a stranger; the process can be traumatic, resulting in behavior patterns such as temper tantrums and regression to infantile activities. To help keep little noses from going out of joint when they find they must share parental attention, the postpartum unit at Calgary General Hospital has developed a unique program called sibling classes.

Held on the unit, the classes are designed to prepare children for the arrival of a new baby; the main objective of these classes is to promote family bonding and to decrease anxiety reactions in children who feel threatened by the new baby. Sibling classes benefit the entire family by:

- providing guidance and support
- developing mutual trust between parents and medical staff
- decreasing sibling fears by increasing awareness of the hospital setting and birthing process
- enhancing sibling bonding and acceptance of the new baby
- helping siblings to feel "as important" as the new baby, and an active rather than passive member of the expectant family.

## Stage one

Class sessions, each of which provides two hours of instruction, are planned for children aged three to nine years whose parents are expecting a baby. A maximum of 10 children participate in each class and the fee for the series is ten dollars. Classes include a tour of the labor and delivery corridor, the post delivery unit, the intensive care nursery and the normal nursery. We make sure that, before going on the tour, the child is in excellent health, having had the proper immunizations and not having been recently exposed to mumps, chicken pox, measles, strep throat or scarlet fever.

Photos courtesy Calgary General Hospital



After the tour, the children return to a small, informal classroom. Each child is connected to a fetal monitor to listen to his own heartbeat; he learns that this is the way staff watch and listen to the new baby before the birth takes place.

Later, the children gather around the instructor to listen to a story about how it feels to have a new baby in the family. Open cribs with large dolls are used to demonstrate holding, feeding and diapering the baby. At this stage, there is plenty of time for discussion and practice and for positive re-enforcement on how well each child performs. Often, mothers who have new infants and are breastfeeding join the group to demonstrate this art to the children in the class. The children are also reminded that some mothers bottle-feed their babies. Once, a physician visited the class to demonstrate an examination of the baby to the children, and each child was given the opportunity to listen to the baby's heartbeat through the stethoscope.

Parents are excluded from this first half of the class; we have found that being on their own encourages the children to participate more freely in discussion. It also helps them to prepare for the subsequent separation from their mother when the baby is actually born. When the parents rejoin the class, an hour later, the entire group watches a film on childbirth featuring animated cartoons dealing with the common misconceptions children have about where babies come from. At this time

we try to answer any questions the children may have about the impending arrival of the sibling. Often, parents have difficulty in discussing sex and reproduction with their growing children. This film provides them with an opportunity to open up new channels of communication on birth and related subjects.

Before he leaves, each child receives a specially designed coloring book that reminds him of the material covered in the class. Each "graduate" also receives a certificate stating that he or she has successfully completed the Big Brother/Sister Course.

#### Stage two

After the arrival of the sibling, and while the mother and babe are still in hospital, a party is held for each child taking the classes. At the party, we serve cupcakes and present the child with a T shirt featuring the message: "New babies are fun! We've got one!"

During the party, the child may hold his new brother or sister for the first time; our aim at this early stage is to encourage the start of a warm and loving relationship. Before he leaves, the child whose party it is, receives a Hero Badge stating that he has a new baby sister or brother.

#### Stage three

After the baby leaves the hospital, the new brother or sister receives a congratulatory letter and a balloon in his own home. In the letter, we suggest that he may call the class instructor if he has any questions or problems.

#### Evaluation

We started this program in 1979, as part of our commemoration of the International Year of the Child. Our evaluation is carried out by means of questionnaires completed by the parents, one after their child has completed the sibling classes, another two weeks after the birth of the baby. Response to date has been very positive: parents agree that the classes help the child to understand the development and birth of a new baby, reduce anxiety connected with the hospitalization of the mother and help the child to feel more involved in the pregnancy and subsequent arrival of the sibling.

We are convinced that the classes not only benefit the children, helping them to adjust to a change in lifestyle, but also foster and facilitate improved relations within the family during the birthing and early bonding process. ♡

*Joy Bliss is the nurse in charge of the sibling classes of Calgary General Hospital. A graduate of Foothills School of Nursing, Joy has worked in renal transplant, ICU, ICN and northern isolation posts. She is currently Clinical Development Nurse Instructor in Obstetrics at Calgary General and, in addition to the sibling classes, teaches prenatal classes for unwed mothers.*


*Author Joy Bliss helps student in sibling classes.*



*Learning how staff watch and listen to their new baby "while he's still in mommy".*







# Nursing mothers then and now

Artwork courtesy La Leche League in Canada

Anne Wallace

## Introduction

As head nurse on our maternity ward, I wanted to demonstrate that hospital nurses could gather the information they need to improve their practice and, at the same time, help the mothers and infants they care for. As a result, five years ago at the Burnaby General Hospital in BC where I work, we initiated a breast feeding survey. Four years later, in 1979, we repeated the survey with the intention of comparing results obtained in the two investigations.

The specific reasons we identified for carrying out this survey were:

- to find out how long mothers nurse their infants after discharge from the hospital
- to discover why mothers stop nursing their infants

- to determine when the majority of mothers introduce solids to the infant's diet

- to uncover teaching problems in our individual counseling and breast feeding classes.

Our first survey was carried out over 10 months, September, 1975 to June, 1976, with 200 mothers; the repeat version covered two months, January and February, 1979, and involved 50 mothers.

## Method

During the survey months all mothers choosing to breast feed were asked if they were willing to participate. As we intended to do our post-discharge follow-up by telephone, we had to eliminate those mothers who did not have a phone, or those who lived in a long distance charge area.

The head nurse in the nursery was responsible for devising the information sheets, collecting the information, and writing up the results. Information sheets were divided into two parts, hospital and follow-up data. A description of the type of information recorded follows:

### *Part I Hospital data*

- personal information: name, age, phone, parity, delivery data, type of delivery, previous nursing time
- baby: birth weight, sex, discharge weight
- problems with previous nursing experience, e.g. cracked nipples, premature baby, sibling jealousy, etc.
- general hospital course of mother and baby
- specific information on nursing in hospital, e.g. schedule, supplementary feedings, etc.
- discharge notes.



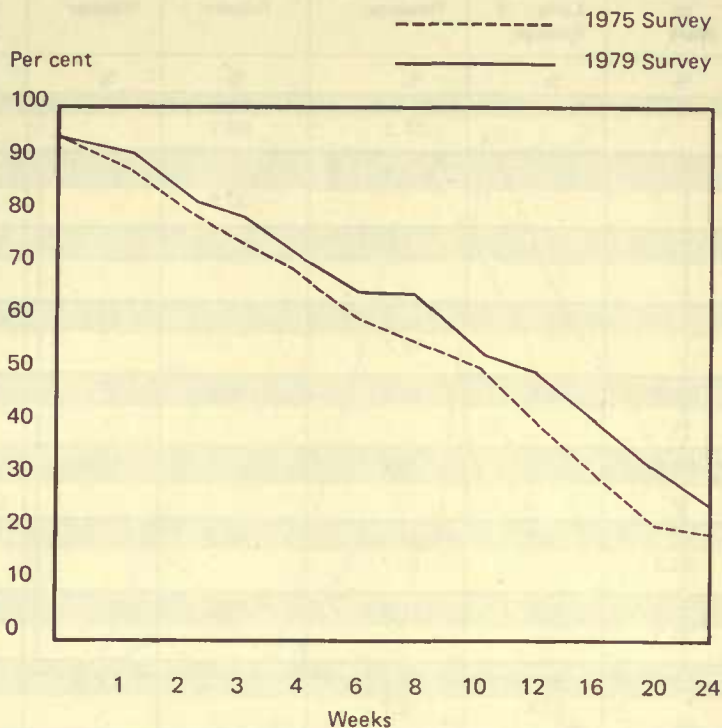


Figure one: Mothers still nursing at specific times

## Part II Follow-up data

- routine questions: are you still nursing? are you using supplementary feedings? if so, how often? are you still nursing at night? what is the feeding schedule? do you follow demand feeding? have you added solids? is your breast milk supply adequate?

- specific nursing problems of mother or baby

- advice given.

The information for Part II was collected by phone on a regular basis: 1st call ..... 1 week after discharge  
2nd call ..... 2 weeks after discharge  
3rd call ..... infant age 8 weeks  
4th call ..... infant age 3 months  
5th call ..... infant age 6 months.  
If no contact was made on the first call, the mother was phoned twice more in a one to two day period, and if still unable to contact the form was filed until the next stage. If no contact was made on this next call, the mother was dropped from the survey.

## Results

### 1. Mothers still nursing at specific times

Figure one summarizes our findings concerning the time at which mothers stopped nursing during the two study periods. In 1975 there was a gradual but steady decline throughout the six month period in the number of mothers continuing to nurse their babies, with a "levelling-off" stage becoming apparent at about four months (16 weeks). All of the mothers who were nursing at 20 weeks were still nursing one month later when their baby was six months of age. Between one and two weeks and again at four to six weeks, the number of nursing mothers dropped sharply (by ten per cent). This was followed by a 12 per cent drop at three months (12 weeks) and another 10 per cent drop between three and four months.

The gradual decline noted on the first survey can also be seen in the 1979 survey; here the significant drop between one to two weeks is still ten per cent, however the decline between four and six weeks is only six per cent this time, a decrease of four per cent from 1975. Another 12 per cent drop was recorded between eight and ten weeks, while a ten per cent drop occurred between five and six months. This ten per cent of mothers who stopped nursing at five months (20 weeks) was not found in the first survey.

### 2. Reasons for discontinuing nursing

This data was very difficult to assess accurately because of the subjective nature of replies. Often when closely questioned mothers had in fact several reasons for stopping at the time they did. In figure two the reasons for discontinuing nursing are correlated with the percentages of mothers who stopped at a given time.

In the first survey, 46 per cent of the mothers stopped nursing because they felt they had insufficient milk to satisfy their infants. The mothers who gave the same reason at the three month check, on closer questioning also said they felt they had nursed long enough. In the second survey 28.9 per cent gave insufficient milk as their reason for discontinuing nursing; only one mother felt that her milk "was not strong enough for the baby".

In 1975, 14.8 per cent of mothers stopped nursing due to sickness of either their baby or themselves; in 1979, sickness accounted for 10.5 per cent including two cases of hospitalization. A third mother successfully nursed her infant while he was hospitalized.

Returning to work meant 4.7 per cent of mothers changed to formula feeding in 1975; this increased to 7.9 per cent in 1979. In this latter survey, however, several mothers returned to work and successfully continued nursing.

Mothers who stopped because they felt they had nursed long enough made up 17.2 per cent in the 1975 group; 47.8 per cent of these mothers stopped at five months. Although this reason was given as early as six weeks in the first survey it did not show up until four months in the second; 37.5 per cent of mothers discontinued nursing for this reason at both four and five months with a total of 21.1 per cent for this category.



Figure two: Reasons for discontinuing nursing  
\*1975 (top row) \*\*1979 (bottom row)

	Insufficient Milk	Sickness	Return to Work	Nursed Long Enough	Social Reasons	No Reason	Sore Nipples	Infant Refused Breast
	%	%	%	%	%	%	%	%
1 Week	*6.7 **9.1	21.0 25.0			33.3	20.0 66.7	50.0	
2 Weeks	16.9 18.2	26.3 25.0			7.7	33.3		50.0 33.3
3 Weeks	6.7	25.0			7.7			
4 Weeks	11.8 18.2	5.3			7.7 16.7		50.0	
6 Weeks	20.3 18.2	10.5	16.6	4.5	15.4	20.0		
8 Weeks	8.4	5.3	16.6		7.7			
10 Weeks	3.3 36.4	5.3	33.3	8.7	23.1 16.7	40.0		
3 Months	13.5	15.7	33.3 33.3	13.0	15.4	20.0		50.0
4 Months	8.4	5.3	16.6	26.1 37.5	7.7 16.7			
5 Months	3.3	5.3	16.6	47.8 37.5	7.7			33.3
6 Months		25.0	33.3	25.0				33.3
TOTAL	46.0 28.9	14.8 10.5	4.7 7.9	17.2 21.1	10.3 15.8	3.9 7.9	1.2	1.6 7.9

In 1975 a total of 10.2 per cent of mothers discontinued nursing for social reasons; the distribution was evenly spread over the six months. Explanations given included such things as nursing was too time consuming, interfered with social life, and that friends and relatives pressured the mother to stop nursing. It should be noted that this survey period included the holiday period of Christmas and New Year. In 1979 social reasons accounted for 15.8 per cent of mothers changing to formula feeding; the highest incidence occurred at one week, 33 per cent, with other drops at four weeks, ten weeks and four months. Explanations given this time were sibling jealousy, interfering with sibling activities such as sports, feeling awkward when nursing, too much company and stress.

In both surveys, some mothers offered no reason for discontinuing nursing; when questioned further some responded that they "just didn't like nursing". The high percentage of mothers giving up nursing in weeks one and two of the 1979 survey fall in this category. Of those offering no reason total percentages were not high at 3.9 for 1975 and 7.9 for 1979.

Sore nipples accounted for 1.2 per cent of mothers discontinuing nursing in the first survey; no mothers gave this reason in the second survey.

Only 1.6 per cent of mothers in the 1975 survey said that the infant refused to nurse; 7.9 per cent gave this reason in the 1979 survey. Those mothers offering this reason at five to six months (66.6 per cent, 1979) said they felt the infant had lost interest and was ready to try something different.

### 3. Age at which the infant started solids

This information was gathered to see if solids were being added to the infants' diets as recommended by nutritionists around four to six months (see figure three). In the first survey solids were started earlier than in the second; 30 per cent at eight weeks in 1975 and 32.3 per cent at twelve weeks in 1979 were peak times. Although still starting solids early, mothers do appear to be delaying longer than a few years ago when soft cereals and fruits were started at two weeks.

### 4. Supplementary feedings

The data showed that 16 per cent of the infants were still on supplementary feedings when leaving the hospital in the 1975 survey and 13.3 per cent in the 1979 survey. Further data on how long these supplementary feedings continued could not be calculated as not all the infants stayed in the study. Supplementary feedings are not given if the mother indicates she prefers not to have them given.



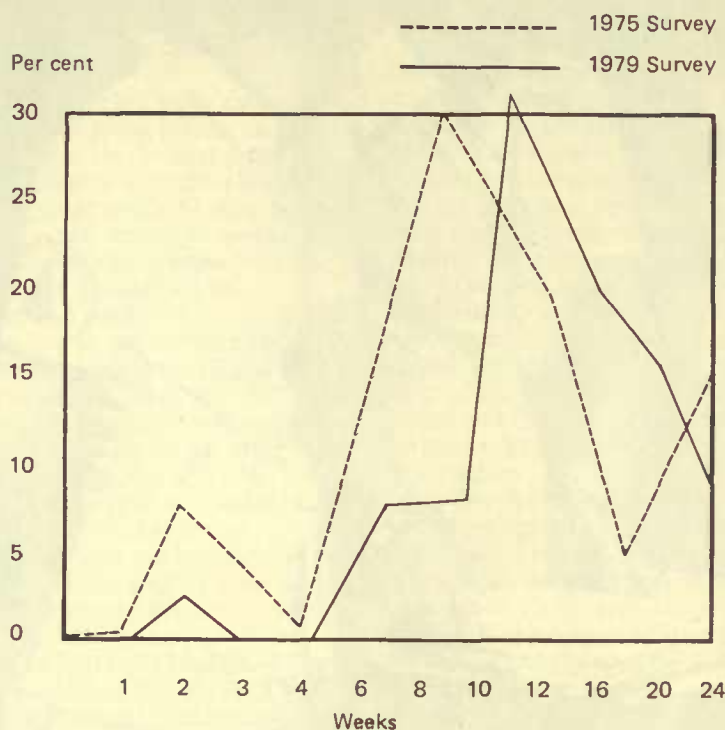


Figure three: Percentage of infants starting solids at specific times

### Discussion

We wanted first of all to establish some facts: how long mothers nursed, why they stopped, and when they added solids to the infant's diet. The description of the survey results shows we achieved this purpose. Meeting our fourth objective was not quite so easy; the results must be interpreted to make them relevant to our nursing practice. The central concern of this discussion will be how we viewed the results, and the action we took.

#### Some specific implications

A large number of mothers gave up nursing in the early weeks giving insufficient milk as their reason; this clearly indicated to us that our message — "lactation is not established for six to eight weeks" — was not understood by these mothers. Convinced of this teaching problem, we do think we improved between 1975 and 1979: the percentage of mothers giving insufficient milk as a reason to discontinue nursing dropped from 46 to 28.9.

As mentioned above, mothers often gave more than one reason making clear cut interpretation difficult. They sometimes added other factors such as pressure from family and friends. We took this to mean that perhaps we did not offer mothers the long term support they needed to clarify their own feelings. Maybe we did not convey to them that the community health nurse was available or that they could call the unit nurses if they had problems in the evenings or on weekend.

#### General interpretation and teaching program changes

Because only 20 per cent of the (1975) mothers who chose to nurse continued until six months, we felt we could improve both our individual counseling and our breast feeding classes. Some steps we took after the 1975 survey:

- we made up special care plans for mothers with particular problems such as sore or inverted nipples
- we urged all mothers to ask for individual help from their assigned nurse when they had problems with feedings

- we distributed pamphlets to all mothers: first, an introductory one for in-hospital use, and later, one for home reference
- we continued our twice weekly classes and tried to improve content and teaching from what we learned in the survey
- we introduced a film for mothers on the first three months of an infant's life, reassuring them that a crying or fussy baby is not always a sign of parental mistakes
- we encouraged sharing of experiences in class discussions; experienced mothers are often very good at reassuring new mothers
- we had the community liaison nurse visit all mothers in hospital, and made referrals for early home visits for mothers having problems.

We think some of our 1979 results indicate progress. One difference we noted was that mothers seemed better able to discuss their reasons for discontinuing nursing; we believe this is important because while we wish to be positive and encouraging about breast feeding, we do not want to make any mother feel guilty if she chooses to do otherwise.

Since the 1979 survey we have started monthly postnatal classes at the hospital; these are informal drop-in sessions to which parents can bring their babies. Common problems and concerns are shared and solutions are exchanged between parents; a nutritionist and a nurse are on hand for teaching and assistance as necessary. We continue to try and improve our program in keeping with our findings; this last is our most recent venture. ❖

**Acknowledgement:** The author would like to acknowledge the cooperation and assistance of the nurses of the Burnaby General Hospital maternity unit and all the parents who participated in the surveys. Special thanks for the help and support of June Nakamoto during the 1975 survey and Maureen Oliver during the 1979 survey, both of whom were coordinators of the maternal/child health department.

Anne Wallace is a graduate of St. Mary's Hospital in Portsmouth, England where she received her SRN and SCM. She has worked in the Vancouver area since 1964, and is presently assistant director of nursing of the maternal-child department at the Burnaby General Hospital.



# Are your students positive about their experience in the clinical area?

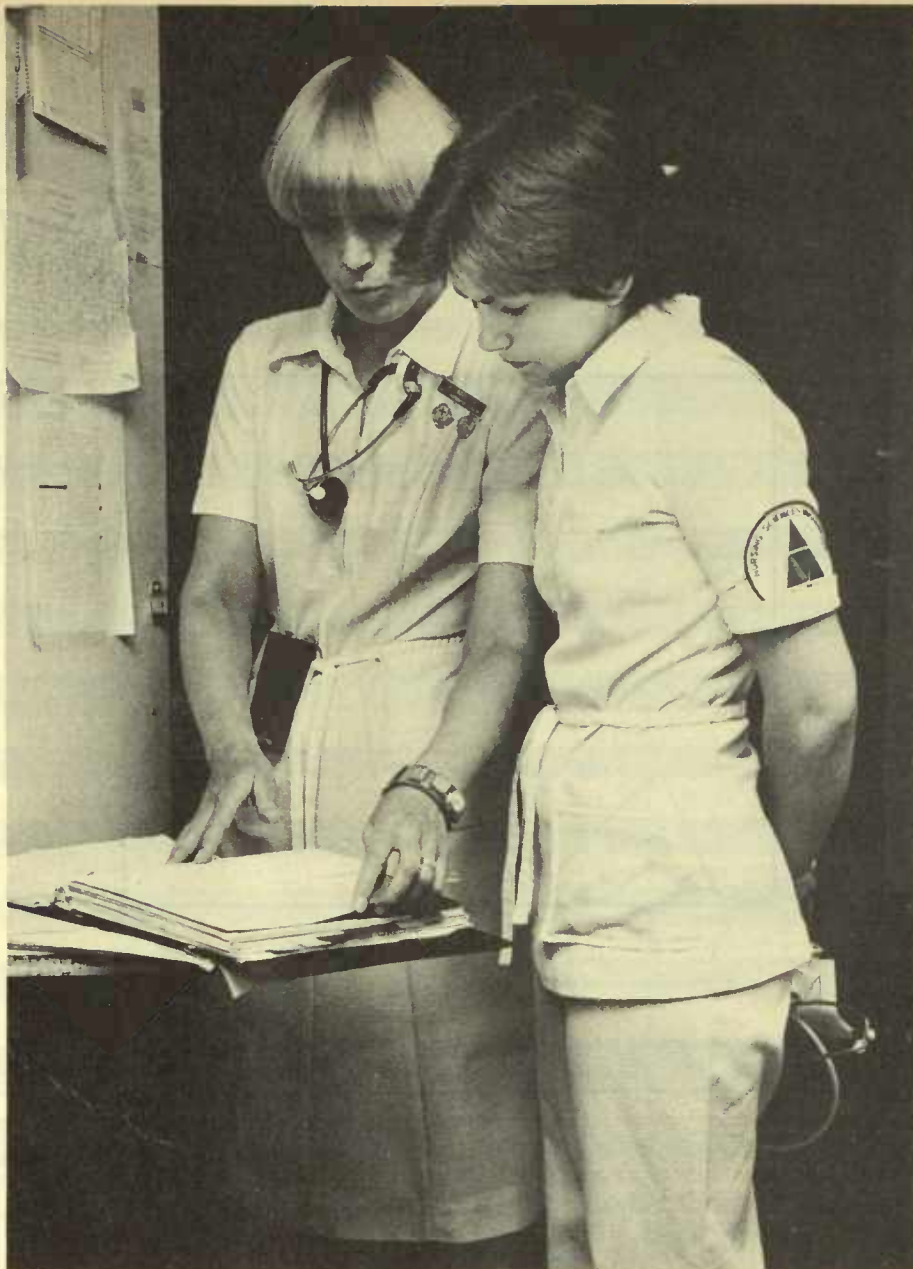


Photo courtesy Studio Impact

*Frances Barr*

Nurse educators are constantly asked to look within themselves for answers to the discrepancy between the clinical competence of their graduates and the service demands of the beginning work role. They know that the time their students spend in the clinical area must be as meaningful and productive as possible. What follows are some practical suggestions for making sure that students find the work setting comfortable and conducive to learning.

## **The clinical area**

An examination of the clinical area, the environment, the people and their roles, is necessary before considering the practical aspects of setting the learning climate.

Consider the patients first since they are central to the learning experience: it is their nursing needs that make up the content of the student's experience. Before patient assignments are made the teacher must consider the ethics of the situation: patient needs must not be compromised by the learning needs of the students. This issue has been debated by Corcoran who claims "to be acceptable, the situation must promote growth and must protect the rights of all persons involved".<sup>1</sup>

Patient selection is crucial to student learning; assignments must be made to provide experiences that are challenging and relevant to the student's

current learning. Does the assignment encourage transfer of classroom theory into practical application? Will patient care allow for some risk-taking and decision-making on the part of the student? Will she be stimulated towards further inquiry and investigation? All of these activities are necessary for learning so the potential for them must exist in the patient assignment.

The type and number of patients available for student experience is also very important. Fluctuations in the ward population are beyond the control of the teacher, so we must be sure to choose areas where the possibilities for learning are reasonably constant and varied. A surgeon's vacation may be enough to radically change the experience available on some surgical units.

Careful preplanning is essential in providing good student experience, but



a certain flexibility must be maintained as unexpected changes are always a possibility on any ward or with any patient.

There is always the possibility that the patient might be better served by having a student caring for him. Not functioning under the same work load as staff, the student may have more time and energy to devote to the patient and this added time may balance the disadvantages of being cared for by a beginner.

Staff nurses and other members of the health team giving patient care in the clinical area are the next group to consider. A degree of conflict with this group is inherent in the differing goals of education and service. If the two are to work successfully, it is essential that the validity of this conflict be recognized and dealt with. Concentrating on the mutual benefits to be derived from the situation and learning to respect the differing expertise of both positions will help. Staff members, in particular, often benefit from the enthusiasm and excitement of students who serve as a morale booster for experienced personnel. Students can also serve as an inspiration, encouraging high standards of care in the role models adopted by staff.

Sexton lists eight benefits to the service organization that she feels result from having students in the clinical area:

- 1 an immediate source of temporary manpower
- 2 screening and recruitment of future employees
- 3 access to skills and knowledge of academic institutions
- 4 opportunities to supervisors and others to learn ways to manage and learn for themselves
- 5 opportunities to examine the teaching and learning dimensions of their own organization
- 6 access to thoughts and attitudes of the young
- 7 invigoration of permanent staff through the presence of students
- 8 fostering credible witnesses (students and faculty) to the nature and worth of the organization in promoting public interest.<sup>2</sup>

Nursing personnel in the clinical area play a vital role in the students' learning experience. They are the primary role models whose attitudes, positive or negative, and techniques are quickly observed and sometimes imitated by students. The degree to which the staff support the educational program and welcome the student and teacher has a profound effect on the learning climate. Janetta MacPhail says:

"Quality nursing practice must exist in a clinical setting, whether that be hospital, nursing home, public health

agency, doctor's office or other setting, to provide an exemplary learning climate for students and staff. Although one can learn from a poor role model what not to do, negative learning is expensive of time and is difficult. A spirit of inquiry and a positive attitude toward learners must exist to permit learners to question and test out new ideas, and to promote learning."<sup>3</sup>

Many other members of the health team also play a role in the students' education, including doctors, dietitians, physiotherapists, clinical pharmacists, social workers and a variety of technicians. It is important that students learn to interact early with these other professionals, who are involved in patient care; it is the best way to become aware of the variety of contributions and methods of team cooperation. Students should also be helped to realize something of the emotional and physical pressure of health care roles and the effects this pressure might have on staff relationships.

The physical setting is another important factor when considering the clinical area for educational purposes. Students are generally assigned to wards in groups of about eight with one teacher. A prime consideration is whether or not the ward can accommodate the influx of a group of this size, both in terms of physical space and actual experience. The whole issue of physical space and nurses has been discussed by Besel under the heading "proxemics":

"We reach the conclusion that, among all health professionals only nurses have so little control over intrusion into personal space. Medical staff, physiotherapists, or occupational therapists who must touch the body, and thus intrude into the patient's personal space, manage to do so on an appointment basis, thereby achieving some modicum of control in this anxiety-provoking situation."<sup>4</sup>

The constant intrusion we must make into the personal space of others and the many intrusions of others into ours is a stress-producing fact of life on a nursing unit. Nurses must often work through difficult decisions in an atmosphere akin to an aquarium. Private office space is generally not available; "the majority of nurses share a stall as a group, for instance, the nursing station. They frequently exert little control over those who will enter that stall, at what time, or for what purpose."<sup>5</sup> Students in the clinical area are affected by this lack of personal space and their presence contributes further to the existing problem. It is very important that the teacher make arrangements to minimize this problem

because of the negative effect on learning. Booking classroom space for student use during clinical hours may help; however, busy clinical facilities are often short of such space or it is reserved for use of staff.

Another dimension of the physical setting that warrants concern is whether or not there is adequate equipment for patient care. If beginning students must constantly adapt or "make do" bad habits may be the result; an attitude of "that's okay in the classroom but it doesn't work in real life" is easily adopted by students if they are constantly frustrated in their attempts to do things correctly.

The teacher's role in the clinical setting is very much that of a catalyst and she is involved in many interactions — with staff, patients, students — all with different responsibilities attached. The level of her expertise as a practitioner and her ability as a teacher will determine the measure of control she can exert over the learning climate. Teachers are also in a position to benefit from the clinical teaching experience: it offers a chance to keep skills and information current.

The student in the clinical area is often the real unknown; although she comes with a defined classroom background, this is theoretical and untested knowledge. Age, maturity levels and other personal factors greatly influence performance, learning styles and communication abilities, a fact that leads us directly to the idea of evaluation of the student in the clinical setting. This area is a source of very real anxiety both for the teacher and the student and therefore must always be considered as influencing the learning climate. The idea of mistakes must be replaced with the notion of clinical choices. Nursing has suffered too long from the need for infallibility; real growth in learning is impossible without the right to fail. This in no way implies that caution can be thrown to the winds but it does mean that we should start being more realistic about our expectations, while still not compromising patient safety.

#### A positive learning climate

If the learning climate is positive, students will feel good about being there, what they are doing and learning and the input and control they have over their experience: in essence they will feel challenged by and able to meet the challenges of the clinical setting.

#### Preplanning

The teacher gives herself a good start if she does a thorough investigation of the clinical area she will be using. Simple but basic things like having a place to meet on the first day are important to an atmosphere of security necessary to



offset the anxiety of a new experience. The information that the students require from the teacher will vary with their familiarity with the facility in use, but the teacher should be sufficiently familiar with her students to know what information is essential, and find an adequate route for getting it to them. Although these may seem to be minor concerns they influence the tone of the teacher-student relationship, an important part of the climate for learning.

#### Communication with staff

The head nurse and staff must be included in the planning of student learning experiences. Before they can do this they will need to know the philosophy of the educational program and the aims of this particular experience. How the teacher initiates and maintains communication in this area will depend on her style and the particular needs of the staff in question. One method that has proven useful is to post weekly objectives for the experience prior to the week and to supplement these with daily objectives written on the assignment sheet for easy reference. Consultation with staff about choice of patients for student assignment provides a time for cooperation and leads to greater involvement of staff in the student's experience.

Making sure that students and staff are introduced to each other is a simple matter but if overlooked will interfere with the communication process vital to relationships for learning. Also the teacher must constantly remember that staff cannot become involved in and support learning experiences if they do not understand them or see their relevance.

#### Orientation

Students require a basic introduction to the physical layout of the ward, the personnel and type of patients, and any routines that are specific to a particular area. This should be done early using whatever methods are suitable to the group and the ward. This can also be part of the process of teacher and student getting to know each other if this is their first experience together. It is very important for the teacher to clarify early her expectations about assignments and participation in group activities and conferences. At the same time students should be encouraged to discuss their personal learning objectives for this experience; these may help the teacher to make assignments that would enhance personal motivation.

#### Patient assignment

Patient assignment must be made soon enough to allow the student necessary

preparation time; if an assignment is a worthy learning experience for the student it will require some forethought and planning. The teacher must be readily available to the student, and the student needs to be aware of the other resources available for her use in the clinical area. Different methods are useful for "being there" for students. I personally prefer the informal approach of walking rounds; a way to see both the patient and student together at the beginning of the experience. Knowing that the student has back-up support gives a certain security to the patient.

#### Conclusion

To work toward the creation of a positive learning climate in the clinical area the teacher must be skilled in both interpersonal relationships and as a nurse practitioner. She is the one who must act as the primary link between ward staff and the nursing school. She must work at being accepted as a member of the ward team if staff are to become committed to the educational program she represents, and must be prepared to remain in the same clinical area for a reasonable period of time to develop constructive relationships with staff.

Before they can respect and care for others, teachers must first respect and care for themselves. "When teachers have essentially favorable attitudes toward themselves, they are in a much better position to build positive and realistic self concepts in their students."<sup>6</sup> In the end, it is the teacher's belief in the student's desire and ability to learn that gives the student the freedom to function more independently. ♣

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\*Not verified

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## AUDIOVISUAL

#### Nursing process

For those interested in planning and conducting workshops on the nursing process, the RNAO has developed a resource package as a teaching aid. The package includes background information, workshop materials and guidelines for use, and information on valuable resources.

The package is available for \$30 from RNAO Publications, 33 Price Street, Toronto, Ontario, M4W 1Z2.

#### Auto Safety For Children

To provide complete factual information on auto safety for children, the Transportation Agency of Saskatchewan has designed a multi-media resource kit. Included in the package is Transport Canada's *Secure Your Child's Future*, and a Canadian Institute of Child Health production, available on both videotape and film. Other resources are a slide tape, overhead transparencies, Transport Canada posters and various brochures. The kit represents an attempt to improve public understanding of the risk factor for unrestrained children in cars, as well as the importance of child safety seats and seat belt use for pregnant women and small children.

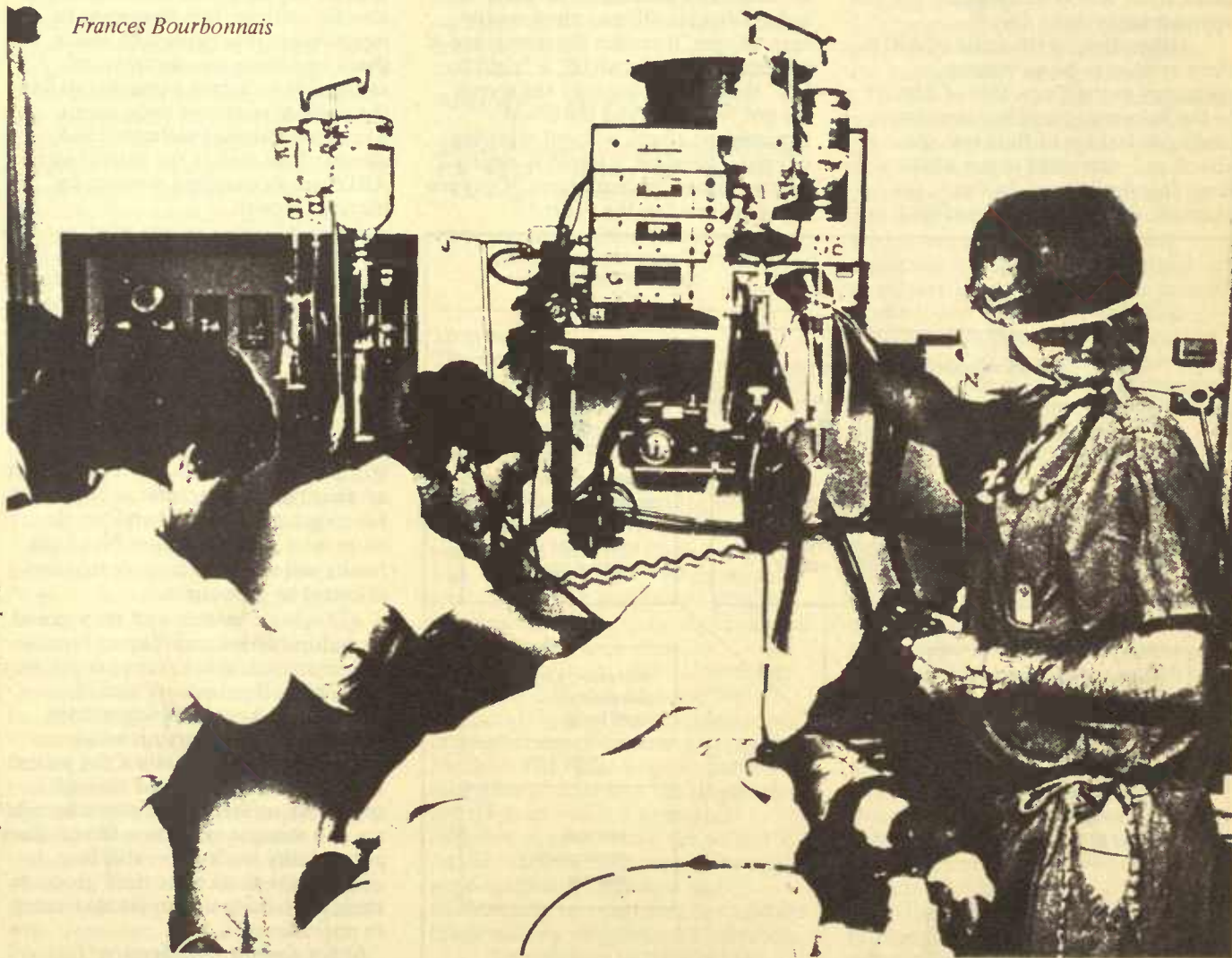
Public health nurses are a key group in the safety campaign, having direct contact with the ideal audience for this kit — young parents and teenagers who will one day be parents; OB nurses, prenatal instructors and teachers are also important.

For more information contact: Harry Gow, Program Coordinator, Canadian Institute of Child Health, Suite 803, 410 Laurier Avenue West, Ottawa, Ontario, K1R 7T3.



# Adult Respiratory Distress Syndrome

*Frances Bourbonnais*



Shock lung, stiff lung or wet lung, whatever the term, nurses who work in an acute care setting are aware that the body's reaction to shock, and its aggressive treatment may result in this acute respiratory condition. Why does adult respiratory distress syndrome occur? How is it treated? What can be done to prevent it?



**Adult Respiratory Distress Syndrome**, sometimes called "shock lung" or "post-traumatic pulmonary insufficiency", refers to a clinical syndrome of acute respiratory failure occurring in critically ill patients. Seen in a diverse group of conditions including multiple trauma, sepsis and shock, adult respiratory distress syndrome (ARDS) is characterized by a severe impairment of gas exchange at the alveolar-capillary membrane in a patient with previously healthy lungs.<sup>1</sup> Within 48-72 hours of the critical insult, it becomes apparent that the patient is experiencing increasing respiratory distress as evidenced by apprehension, dyspnea, tachycardia and a falling arterial oxygen level ( $PO_2$ ). Despite high concentrations of oxygen, the  $PO_2$  continues to fall (see figure one).

Typically, the patient is admitted to hospital with severe trauma and is in both a hypoxic and shock state. Despite a successful resuscitation from this shock state, ARDS develops in approximately three days.<sup>2</sup>

Regardless of the cause of ARDS, there appears to be a common pathology in the lungs, that of damage to the pulmonary capillary membrane leading to leakage of fluid into the alveoli and interstitial spaces of the lungs (see figure two). In shock, for example, the lung is underperfused, as

blood is being directed to the heart and brain. Lack of perfusion of the lung tissue is accompanied by lack of oxygen. This hypoperfusion and hypoxia create increased pulmonary capillary permeability leading to interstitial edema which causes the lungs to become very stiff and the compliance of the lungs decreases. This stiffness of the lungs increases the mechanical work of breathing.<sup>3</sup>

In ARDS, surfactant production is also decreased. Surfactant, a lipoprotein produced by Type II alveolar cells in the lungs, helps prevent collapse of the alveoli. Therefore, a reduction in surfactant leads to atelectasis. Also in ARDS, thromboemboli are found in the small pulmonary blood vessels.<sup>4</sup>

The net is that of arterio-venous shunting. Arterio-venous shunting creates a low arterial oxygen level as oxygen is not transported across the alveolar-capillary membrane because of edema and atelectasis. However as carbon dioxide diffuses more readily than oxygen, it crosses the membrane to a greater extent. In ARDS, a "right to left" shunt exists whereby the alveoli are not ventilated and the blood bypasses the alveoli without receiving oxygen. Therefore, a low  $PO_2$  results despite higher concentrations of oxygen being delivered to the patient.<sup>5</sup>

## Etiology of ARDS

The development of ARDS involves a multitude of factors, one or several of which may be present in the patient who develops this syndrome.<sup>6</sup>

1. **Fluid overload.** Excessive use of crystalloid fluids in the resuscitation of the shock patient can lead to ARDS. Crystalloid fluids, such as normal saline, contain no protein and thus dilution of the colloid osmotic pressure occurs. The resulting loss of fluid into the interstitial spaces, particularly the lung, creates a stiff lung with little compliance. The effect created is that of increased effort of respiration and decreased diffusion of oxygen into the capillaries because of fluid in the interstitial spaces and eventually fluid in the alveoli. Therefore, the amount of crystalloid fluid given to patients in shock must be closely monitored.

2. **Sepsis** can cause the release of toxic agents such as endotoxins which can result in the leakage of fluid through the alveolar capillary membrane leading to alveolar collapse. It is important to remember that patients with severe shock and tissue trauma are more susceptible to broncho-pneumonia and the possible release of toxic agents. Also, the increasing atelectasis and alveolar fluid seen in the patient with ARDS are an excellent medium for bacterial growth.

3. **Oxygen toxicity** occurs when patients are exposed to high concentrations of oxygen (greater than 60 per cent) for prolonged periods of time. The lungs, eyes and central nervous system can all be affected. Pulmonary damage due to high concentrations of oxygen over prolonged periods cause damage to the alveolar Type II cells which produce surfactant resulting in atelectasis. Within 30 hours of 100 per cent oxygen administration, a decrease in pulmonary function can be seen. Therefore, the nurse must closely monitor blood gas results and the oxygen concentration delivered to the patient.

4. a) **Emboli.** Patients who are exposed to multiple blood transfusions because of hemorrhagic shock, for example, may develop small pulmonary emboli. Banked blood contains degenerated platelets and fibrin strands which can lead to pulmonary emboli if the patient does not receive the blood through a special microfilter. These microthrombi are also thought to increase the capillary permeability leading to a stiff lung. In addition the shock state itself produces stasis of blood in the capillaries leading to microthrombi.

b) **Fat Emboli.** High levels of free fatty acids may be seen in patients with fractures of long bones. These free fatty acids can inactivate the production of surfactant and may also have a toxic effect on the alveolar-capillary

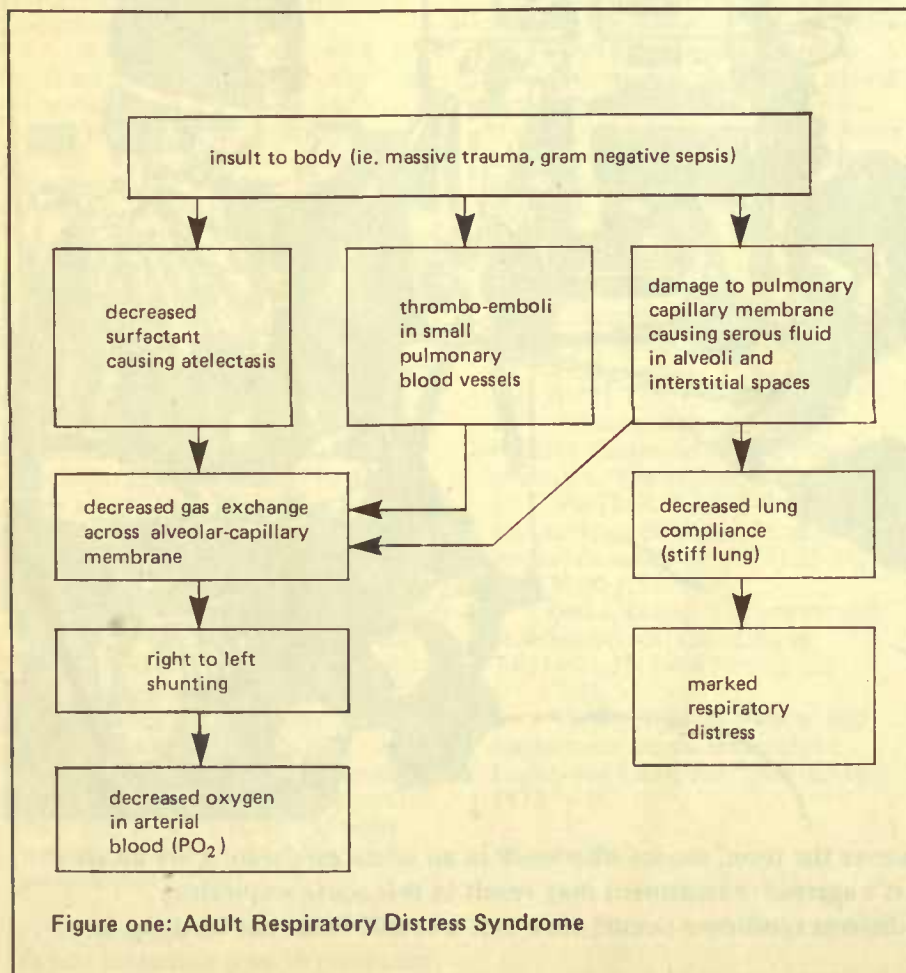


Figure one: Adult Respiratory Distress Syndrome



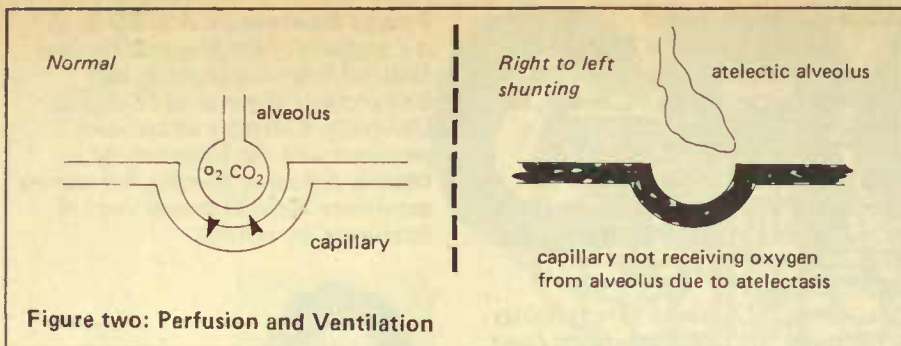


Figure two: Perfusion and Ventilation

membrane causing production of exudate in the small airways. Early immobilization of fractures is vital to help prevent the development of these fat emboli.

*c) Disseminated Intravascular Coagulation.* This disorder may be seen in the patient with shock and is a paradox of simultaneous clotting and bleeding, producing microthrombi in the lung.

### Phases of ARDS<sup>7</sup>

*Injury and Resuscitation.* In this phase the patient has been resuscitated from a shock state. Arterial blood gases reveal that the patient's  $PO_2$  level is starting to decrease, but with supplemental oxygen it remains at a satisfactory level. The patient in this stage tends to hyperventilate resulting in an increased respiratory rate and a decreasing arterial carbon dioxide level ( $PCO_2$ ). At this stage of ARDS, the patient may recover with no permanent lung damage.

*Circulatory Stabilization.* Tissue perfusion has been restored in the patient and the cardiac output is good. The patient is lucid and oriented but may show signs and symptoms of early respiratory difficulty such as tachypnea. In this stage, supplemental oxygen does not return the  $PO_2$  to a normal level. This indicates that arterio-venous shunting is occurring. However, with treatment, the patient will recover.

*Progressive Pulmonary Insufficiency* At this stage, the patient displays marked dyspnea. Despite higher and higher concentrations of oxygen therapy, the  $PO_2$  continues to fall. In addition, the  $PCO_2$  level may begin to rise above normal levels. Both these factors indicate a marked decrease in the diffusion of gases at the alveolar-capillary membrane. To maintain adequate oxygenation of tissues, support with a mechanical ventilator is required. It is still possible for the patient to recover at this phase with treatment.

*Terminal Hypoxia and Increased  $PCO_2$ .* During this phase which usually lasts only a few hours, the hypoxia is so severe that the patient may have a cardiac arrest from the lethal cardiac arrhythmias that are prone to develop.

The  $PCO_2$  continues to rise and because of the very low  $PO_2$  and lactic acid buildup, the patient develops metabolic acidosis. The patient deteriorates into a deepening coma and finally cardiac standstill occurs. The patient usually succumbs regardless of treatment. Chest x-rays during this period reveal a diffuse white-out of lung tissue similar to pulmonary edema. On autopsy, the patient's lungs resemble liver tissue. They are inflated and saturated with fluid which makes them heavy and stiff.

### Arterial $PO_2$ and $PCO_2$ in ARDS

(before treatment with ventilator and PEEP)  
 $PO_2$ : 40-50 mmHg with 100% inspired oxygen (normal is 85-100 mmHg)

$PCO_2$ : initially less than 35 mmHg, in phase IV greater than 50 mmHg (normal is 35-45 mmHg)

### Treatment

The increasingly stiff lungs of the patient with ARDS make it difficult for the patient to breathe on his own. Therefore, treatment usually involves maintenance of the patient on a ventilator to decrease the work of breathing and to ensure adequate oxygenation of tissues. The use of positive end expiratory pressure (PEEP) with a ventilator is the recommended treatment. PEEP maintains a positive pressure in the alveoli during expiration thus preventing atelectasis, by preventing collapse of the alveoli. By improving diffusion of gases, the patient's  $PO_2$  level increases and lower concentrations of inspired oxygen are required. PEEP also helps to prevent the migration of fluid into the alveoli, the net effect of which is to improve diffusion of gases. While the patient is on the ventilator, the nurse must apply good suctioning technique and tracheotomy care, in order to minimize the possibility of pulmonary infection.

Steroids may be used in the treatment of ARDS although the exact mechanism of their action with this syndrome is not clearly understood. However, it is believed that steroids prevent platelet clumping, increase

surfactant production, block the effect of endotoxins and maintain cell integrity. The nurse must observe the patient carefully for the many side effects such as gastric ulceration which complicate steroid therapy.<sup>8</sup>

Since excessive administration of fluids potentiates the development of ARDS, diuretics may be used to help control fluid volume, particularly pulmonary fluid volume. However, with the shock patient, care must be taken that the diuretics do not deplete the intravascular volume and lead to another severe episode of shock. Close monitoring of intake and output and the patient's response to diuretics is essential.

At the earliest signs and symptoms of infection, antibiotic use is considered. Appropriate smears and cultures should be obtained regularly and any indications of infection reported.<sup>9</sup>

### Nursing measures

The treatment of ARDS begins with prevention which falls largely within the responsibility of the nurse.

Resuscitation of the shock patient and maintenance of adequate tissue perfusion is essential in preventing the development of ARDS. Without correction of poor tissue perfusion, circulatory stasis increases and thromboemboli result. While fluid replacement is essential in the shock state, careful monitoring of the patient's intake is necessary to prevent fluid overload. The nurse must be cognizant of the patient's response to fluid therapy as indicated by blood pressure, pulse rate, urine output, skin perfusion, central venous pressure and by auscultation of the lungs for detection of fluid (rales).

As fluid therapy for the patient in shock usually involves blood transfusions, the nurse should ensure that filters are used for all such infusions. The filters should be fine enough to prevent particulate matter in the blood transfusion from entering the circulation and forming emboli in the lungs.

Pulmonary function is also compromised by pain which can result in decreased respiratory effort and increased pulmonary secretions. While analgesic administration is important to reduce these reactions, it is essential to beware of oversedation which depresses respiratory function.

Patients in shock have decreased resistance to infection for several reasons. For example, the reticulo-endothelial system may be depressed because of poor perfusion and the mucosal barrier in the intestine may become increasingly permeable to bacteria leading to the release of toxins.



Careful observation by the nurse of any signs of developing infections can minimize further lung damage from occurring.

Oxygen should be administered to the patient in shock as the resulting decreased cardiac output may lead to inadequate tissue oxygenation. Careful monitoring of blood gases, the response to oxygen therapy and the levels of inspired oxygen are vital to help prevent oxygen toxicity.

The nurse should be particularly cognizant of naso-gastric tube placement and its patency because a malfunctioning naso-gastric tube can lead to aspiration of gastric contents resulting in infection and pneumonia. In addition, a blocked naso-gastric tube can lead to gastric distention which contributes to shallow breathing and the subsequent development of atelectasis.<sup>10</sup>

Finally, the basic nursing measures of regular turning, encouraging coughing and deep breathing and chest physiotherapy on a 24-hour basis may be the most important ingredients in preventing the development of atelectasis and pneumonia which further compromise your patient's chances in dealing successfully with ARDS. ❖

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\*Not verified

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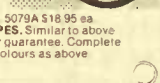
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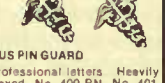
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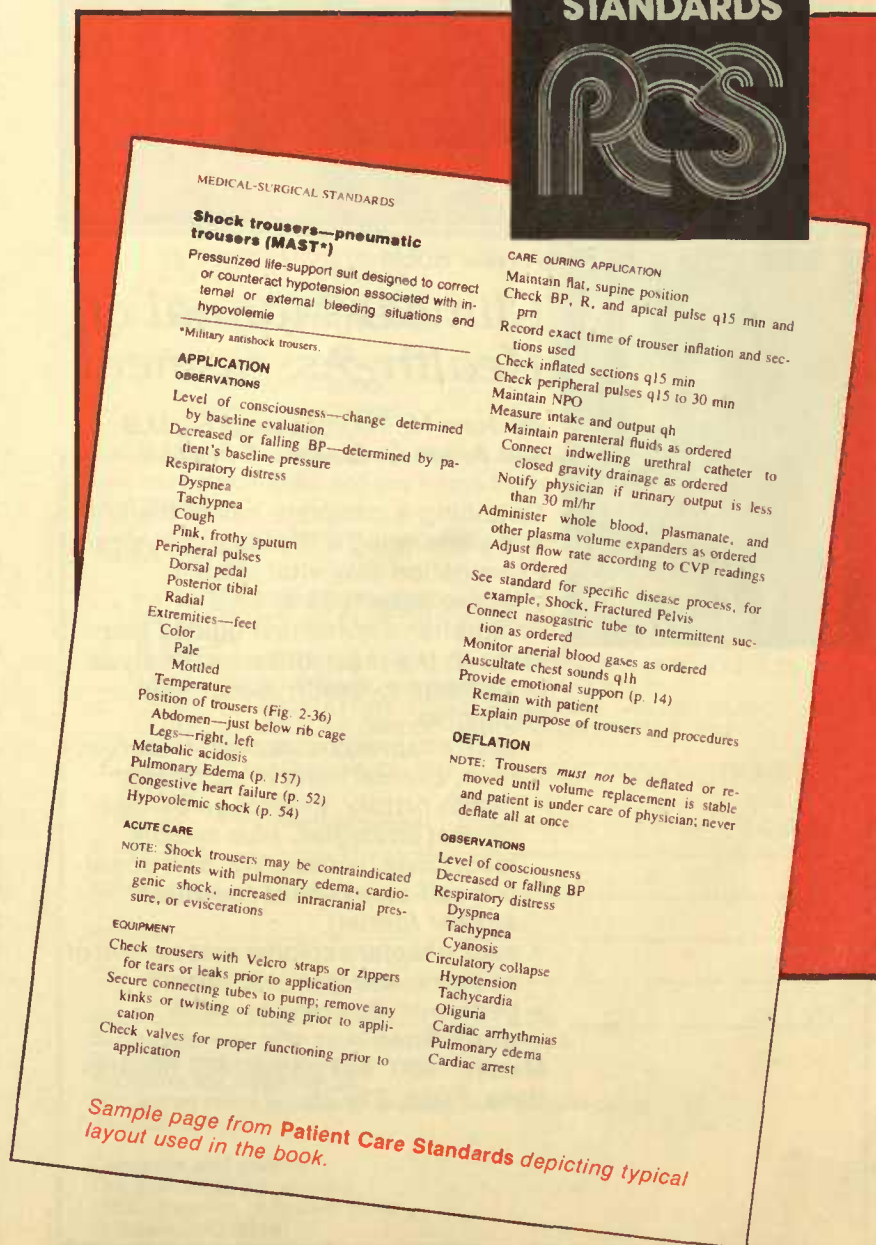
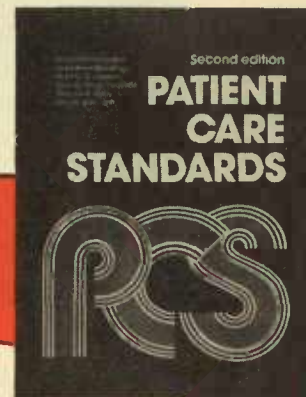
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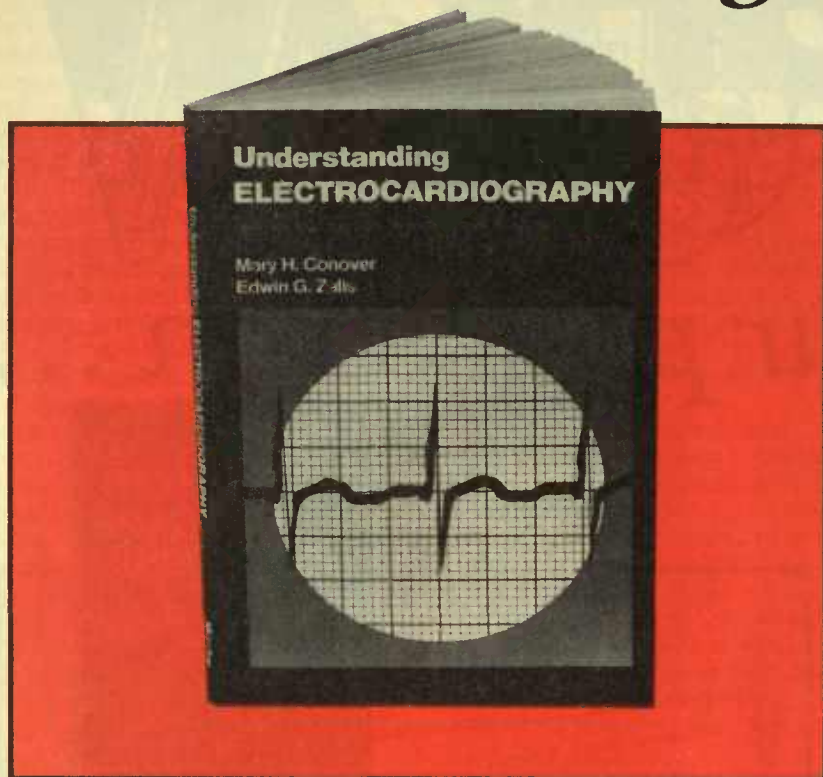
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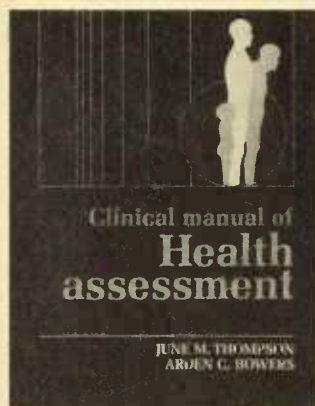
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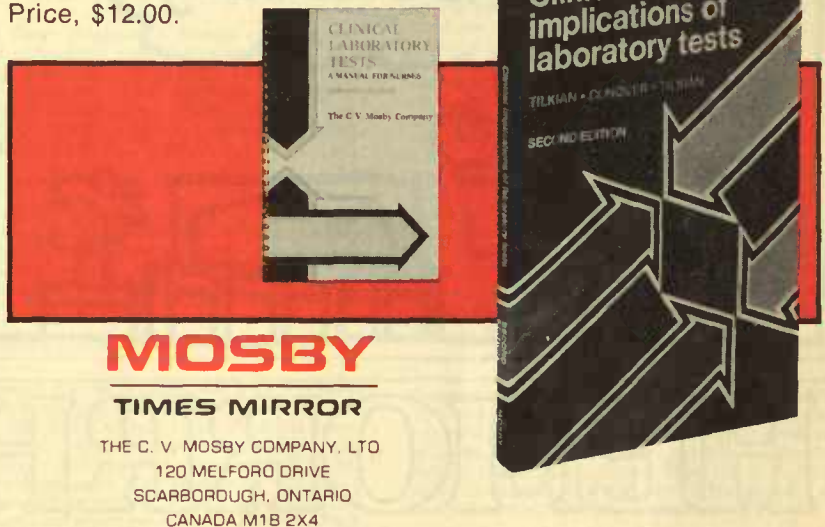
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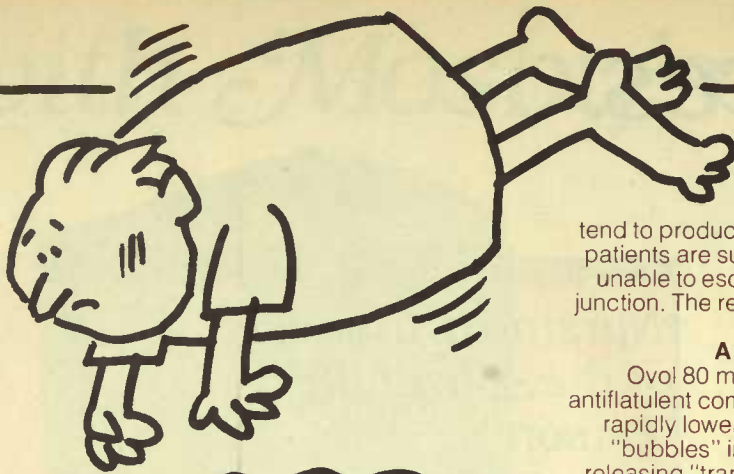
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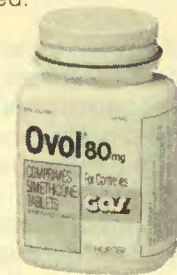
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Also supplied as peppermint-flavoured Ovol Drops for relief of infant colic.

**FAST,  
EFFECTIVE RELIEF  
OF GAS.**

**HORNER**  
Montreal, Canada

Prescribing information on page 16.

PAAB  
CCPP

# HEMORRHOIDS?

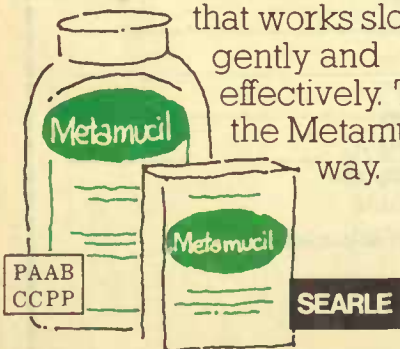
When your patient has hemorrhoids, constipation should be avoided. The bowel may need a little gentle prompting to begin functioning normally again, and that's where Metamucil can help. Why not recommend a laxative that works slowly, gently and effectively. That's the Metamucil way.

Metamucil is made from (gluten-free) grain, providing fiber that produces soft, fully formed stools to promote regular bowel function.

Available as a powder (low in sodium) and a lemon-lime flavoured Instant Mix (low in calories). Why not give your patients our helpful booklet about constipation?



**Metamucil®**  
The laxative most recommended by Physicians.



PAAB  
CCPP

SEARLE



# Classified Advertisements

## Alberta

**Registered Nurses.** We invite you to join our Health Care Team at the Fort McMurray Regional Hospital which is expanding from a 75-bed hospital to a 300-bed hospital. We will provide you with a challenging professional opportunity as a primary nurse involved in our high level patient care programs. Good employee benefits, salary as per the Collective Agreement and registration as per the A.A.R.N. Please contact: Human Resources, Fort McMurray Regional Hospital, 7 Hospital Street, Fort McMurray, Alberta T9H 1P2, (403) 743-3381, ext. 19.

**Registered Nurses required in a 68-bed active treatment hospital in Northeastern Alberta.** Applicants will be required to assume responsibility of a given unit—Pediatrics, Emergency, Obstetrics or Medicine and must be willing to rotate all shifts. Accommodation for temporary or permanent residence is available in the Nurse's Residence. Salary and benefits in accordance to the newly negotiated provincial agreement. Apply in writing to: Director of Nursing, Lac La Biche General Hospital, Box 507, Lac La Biche, Alberta T0A 2C0.

**Graduate & Registered Nurses required immediately.** Opportunity to acquire experience in all clinical areas of a 75 bed accredited hospital (located 130 miles N.E. of Edmonton, Alberta). (Time off in lieu of vacation negotiable). Salary and fringe benefits in agreement with U.N.A. (\$1465-\$1867). Contact: Director of Nursing, St. Therese Hospital, Box 880, St. Paul, Alberta T0A 3A0 (Phone) 403-645-3331.

**Required—Full-time and part-time Registered Nurses** to rotate all three shifts in Active Treatment 66-bed hospital. Apply to: Director of Nursing, Taber General Hospital, Box 939, Taber, Alberta T0K 2G0.

## British Columbia

**Experienced General Duty Graduate Nurses** required for small hospital located N.E. Vancouver Island. Maternity experience preferred. Personnel policies according to RNABC contract. Residence accommodation available \$30 monthly. Apply in writing to: Director of Nursing, St. George's Hospital, Box 223, Alert Bay, British Columbia V0N 1A0.

**Director of Nursing—Ashcroft and District General Hospital, Ashcroft, British Columbia,** 27 acute, 8 extended and 6 long term care beds invites applications for the position of Director of Nursing. Must be eligible for registration within the province of British Columbia. Advanced education and clinical administration experience preferred. Hospital is fully accredited. Please apply with resume and references to G.P. Holgate, Administrator, Ashcroft and District General Hospital, P.O. Box 488, Ashcroft, British Columbia V0K 1A0. Telephone (604) 453-2211.

**General Duty Nurses** required for 30 bed accredited hospital. Salary according to RNABC Contract. Apply: Administrator, Chetwynd General Hospital, Box 507, Chetwynd, British Columbia V0C 1J0. (604) 788-2236/2568.

## British Columbia

**General Duty Nurses** for modern 41-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, P.O. Box 60, Fort Nelson, British Columbia V0C 1R0.

**General Duty Nurse** for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurse's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia V0H 1H0.

**General Duty Registered Nurses** required for 108-bed accredited hospital in northwest B.C. Previous experience desirable. Salary as per RNABC Contract with northern allowance. For further information, please contact: Director of Nursing, Kitimat General Hospital, 899 Lahakas Blvd. N., Kitimat, B.C. V8C 1E7.

**Small hospital located in West Kootenay area of B.C.** requires experienced RN for maternity relief. Begins December 1, 1980—may lead to permanent position. Apply to Slocan Community Hospital, Box 129, New Denver, British Columbia V0G 1S0.

**Experienced Nurses (eligible for B.C. Registration)** required for full-time positions in our modern 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC Contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia V3L 5E8.

**Royal Columbian Hospital—Experienced Nurses (B.C. Registered)** required for this 500-bed progressive regional referral and teaching hospital located in the Fraser Valley, 20 minutes by freeway from Vancouver and within easy access of various recreational facilities. Excellent orientation and continuing education programmes. Salary — 1980 rates — \$1624.00 - \$1889.00 per month. Clinical areas include: Operating Room, Recovery Room, Intensive Care, Coronary Care, Neonatal Intensive Care, Labour and Delivery, Family centred Obstetrics, Emergency, Renal Dialysis, Psychiatry, Acute Medicine, Palliative Care, Surgery, Pediatrics, Rehabilitation and Extended Care. Please apply in writing to: Employment Manager, 330 East Columbia Street, New Westminster, British Columbia V3L 3W7.

**Experienced nurse (eligible for B.C. Registration)** required for full time position in our lovely cottage hospital on northern Vancouver Island. Apply to the: Port McNeill and District Hospital, P.O. Box 790, Port McNeill, British Columbia V0N 2R0.

## British Columbia

**General Duty Nurses** required by an active 80-bed acute care and 40-bed extended care hospital located in the Cariboo region of B.C.'s central interior. Year round recreational activities in this fast growing community. Applicants eligible for B.C. registration preferred. Apply in writing to: The Director of Nursing, G.R. Baker Memorial Hospital, 543 Front Street, Quesnel, British Columbia V2J 2K7.

**General Duty Nurses** required immediately for a ten-bed acute and ambulatory care hospital located in Stewart, B.C. Stewart has a population of 2000 and is Canada's northernmost ice-free port with transportation, mining and construction as its primary industries. There are excellent school facilities. A few of the many sports offered are boating, fishing and, in the modern community pool, swimming. Stewart General Hospital is affiliated with the Prince Rupert Regional Hospital and nurses are encouraged to take part in the inservice education programmes at both hospitals. Salary rates are according to the RNABC contract and for a general duty RN the ranges are: May 1, 1980—\$1624-\$1889 plus \$26.87 northern allowance. Jan. 1, 1981—\$1700-\$1965 plus \$28.12 northern allowance. Fringe benefits include: 20 days paid annual vacation; 5 days marriage leave; annual educational leave, in addition to the other usual health care insurance and monetary benefits. We are eager to help you relocate. For further information please call COLLECT: (604) 624-2171, ask for Mrs. L. Bremner, Director of Nursing.

**General Duty Nurses** required for an active, 103-bed hospital. Positions available for experienced R.N.'s and recent Graduates in a variety of areas. RNABC Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

**O.R. Head Nurse** required for an active 103-bed acute care hospital. Must be eligible for B.C. Registration. Post graduate training & experience necessary. R.N.A.B.C. Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

The Cancer Control Agency of British Columbia is seeking two Chemotherapy Nurse Clinicians. Master's Degree preparation in nursing is preferred. Successful applicants for these positions will have demonstrated abilities to carry a patient case load, work on an interdisciplinary oncology team, and teach nurses about the care of oncology patients and their families. Teaching responsibilities are in the A. Maxwell Evans Clinic in Vancouver and throughout the Province of British Columbia. These two positions will provide a challenging opportunity for the advanced practice of nursing, as well as experience in teaching and the implementation of oncology nursing standards. Interested applicants should phone or write: Sue Rothwell, Director of Nursing, Cancer Control Agency of British Columbia, 2656 Heather Street, Vancouver, B.C. V5Z 3J3. Phone: 604-873-4221.



## British Columbia

**Registered Nurses**—Full-time and casual relief positions are available at the University of British Columbia, Health Sciences Centre, Extended Care Unit. The 12 hour shift, the problem oriented record charting system, an emphasis on maintaining a normal and reality based clinical environment and an interprofessional approach to management are some of the features offered by the Extended Care Unit. Interested applicants may enquire by calling 228-7025 or 228-7000. Positions are open to both male and female applicants.

## Manitoba

Registered nurses required for a fully accredited 100-bed general hospital and a 72-bed personal care home located in northern Manitoba. Must be eligible for registration in Manitoba. Salary dependent on experience and education. For further information contact: Mrs. Mona Seguin, Personnel Director, St. Anthony's General Hospital, The Pas Health Complex Inc., P.O. Box 240, The Pas, Manitoba R9A 1K4; or phone collect to: 1-204-623-6431, Ext. 179.

## Northwest Territories

The Stanton Yellowknife Hospital, a 72-bed accredited, acute care hospital requires registered nurses to work in medical, surgical, pediatric, obstetrical or operating room areas. Excellent orientation and inservice education. Some furnished accommodation available. Apply: Assistant Administrator-Nursing, Stanton Yellowknife Hospital, Box 10, Yellowknife, N.W.T., X1A 2N1.

## Ontario

**Looking For A Temporary Change?** Do you want to keep your job but feel the need for some renewing experience? International registry for nurses interested in a temporary job exchange under organization. Write: Nursing Job Exchange, Box 1502, Kingston, Ontario K7L 5C7.

Registered Nurses required. Hospitals located on James Bay at Attawapiskat and Fort Albany. Good salary scale plus Northern Allowance. Accommodations provided. Enjoy a Northern Experience. For further information, contact: The Administrator, James Bay General Hospital, P. O. Box 370, Moosonee, Ontario POL 1Y0.

RN or RNA 5'6" or over and strong, without dependents. Non-smoker for 180 lb. handicapped retired executive with stroke. Able to transfer patient to wheelchair. Live in 1/2 year in Toronto, 1/2 year in Miami. Wages \$250.00 to \$325.00 weekly *net* plus \$100.00 weekly bonus on most weeks in Miami. Free room and board. Write M.D.C. 3532 Eglinton Ave. West, Toronto, Ontario M6M 1V6.

## Saskatchewan

General Duty R.N.'s required immediately for a 20 bed Rural Hospital located near provincial park. New hospital, modern equipment, all areas of nursing done, surgery, obstetrics, pediatrics, emergency and general medicine. Modern community, bus services, paved streets, etc. Wages and fringe benefits as per 1980 S.U.N. provincial agreement. For further information please contact: Administrator, Porcupine-Carragana Union Hospital, Box 70, Porcupine Plain, Saskatchewan S0E 1H0. Phone (Bus) 278-2233 or 278-2211 (Res) 278-2450.

## Saskatchewan

**Psychiatric Nurses**—Saskatchewan Health, Psychiatric Services Branch, Psychiatric Centre in Prince Albert, and the Saskatchewan Hospital North Battleford, in North Battleford, require graduates from approved School of Psychiatric or General Nursing. Both centres are adjacent to Saskatchewan's finest outdoor recreational areas. Excellent benefits and an opportunity to experience career and personal growth through in-service education and on-the-job training exist. Incumbents will provide specialized psychiatric nursing care, procedures and treatment, and have supervisory responsibility over junior staff and aides. Applicants must be eligible for registration as Nurses in Saskatchewan. Location preference should be specified. Salary: \$17,088-\$19,644 (Nurse 1), \$17,664-\$20,352 (Senior Nurse 1). Salaries commensurate with experience and qualifications. Competition: 604100-0-745 (Prince Albert) 3 positions. Competition: 604111-0-783 (North Battleford) 18 positions. Closing: As soon as possible. Forward your application forms and/or resumes to the Saskatchewan Public Service Commission, 3211 Albert Street, Regina, S4S 5W6, quoting position, department and competition number.

## United States

**California**—Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, Ext. 1680.

**RN/Staff & Management Positions**—Kaiser-Permanente, the country's largest Health Maintenance Organization, currently has excellent opportunities available in our 583-bed Los Angeles Medical Center. Located 7 miles from downtown Los Angeles, close to many of California's finest Universities, this teaching hospital offers RN's a unique chance to further their careers in such areas as: OR, Med/Surg, Maternal Child Health & Critical Care. Management positions are also available. Kaiser offers an attractive array of fringe benefits including relocation assistance, full medical, dental & health coverage, continuing education advanced training available in the Nurse Practitioner & CRNA Programs, individualized orientation, tuition reimbursement, and no rotating shifts. New graduates are always welcome and encouraged to inquire. For more information, please write or call collect: Ann Marcus, RN, Kaiser Hospital/Sunset, 4867 Sunset Blvd., L.A., California 90027. (213) 667-8374.

Total patient care with all licensed personnel is our goal! Staff RNs currently interviewing for part-time and full-time positions. Full service, except psych, progressive 156-bed accredited acute general hospital. Located within 60 minutes from L.A., the ocean, mtns., and the desert. Orientation and staff development programs. CEUs provider number. Parkview Community Hospital, 3865 Jackson Street, Riverside, California 92503. Write or call collect 714-688-2211 Extension 217. Betty Van Aernam, Director of Nursing.

Enterostomal therapy education program. Eight-week program for registered nurses offered several times annually. Specialized care of adults and children with abdominal stomas, with draining wounds, related skin problems, and decubitus ulcers. Contact: Program Director, Enterostomal Therapy Education, The University of Kansas School of Nursing, 39th and Rainbow Boulevard, Kansas City, Kansas 66103.

## United States

**RN'S**—Our Florida hospitals need you! Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. No Fees! Call or write: Medical Recruiters of America, 3421 West Cypress St., Tampa, Florida 33607 (813) 872-0202.

**Registered Nurses Virginia, USA**—The Medical College of VA Hospitals is a 1058 bed, full service, referral, and research University hospital comprised of 50 specialty units within the nursing department; including Oncology, Medicine, Surgery, OB/GYN, Pediatrics, Critical Care, OR/RR and Outpatients. You may specialize in nursing and continue education through in-service workshops or pursue B.S.N. or M.S.N. (100 percent tuition reimbursement for 12 credits/year) in our school of nursing. We offer competitive salaries and fringe benefits. Personal interviews will be arranged. To learn more call collect 804-786-0918 or write to Wanda Barth, MCV Hospitals, Box 7, Richmond, VA 23298. An Equal Opportunity Employer.

**Catholic Relief Services** seeks medical personnel for Health Center in Hodeidah, Yemen Arab Republic. Openings include specialized nurse clinicians: Dir/Nursing, administration, supply, ER, supervision, Peds, OB-GYN, ENT, Med-Surg, burns, outpatient; also midwife, medical records, educator, accounting/bookkeeping, secretarial, office manager, language teacher. Support includes housing, neg. living stipend, generous leave. All positions volunteer. Contact: CRS-Region 1, 1011 1st Ave., NYC 10022, 212/838-4700.

## Miscellaneous

**Adventure Holidays**: Camping Safaris, Overland Expeditions and Fun Experiences. We offer trips from one week to 3 months in: Canada, USA, Europe, Africa, Asia, South and Central America, Australia, New Zealand and the Caribbean. For FREE catalogue, contact your travel agent, or apply to: Goway Travel, 53 Yonge St., Suite 101, Toronto, Ontario M5E 1J3. Phone: 416-863-0799. Telex: 06-219621.

**Aloe-Vera** — Positions now available for persons interested in skin care who wish to retail natural aloe skin care products. Contact Ms. C. Crowe-Sturino, 15 Stonehouse Cres., Toronto or call (416) 534-2925.

**Before accepting any position in the U.S.A. PLEASE CALL US COLLECT We Can Offer You:**

- A) Selection of hospitals throughout the U.S.A.
- B) Extensive information regarding Hospital—Area. Cost of Living, etc.
- C) Complete Licensure and Visa Service

**Our Services to you are at absolutely no fee to you.**

**WINDSOR NURSE PLACEMENT SERVICE**

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## General Hospital

St. John's, Newfoundland

A completely modern teaching hospital requires an **Operating Room Manager**.

This 500-bed General Hospital is the major teaching facility for the Medical School of Memorial University of Newfoundland.

Services offered:

**Critical Care (Medical-Surgical), Coronary Care, General Surgery, Urology, Gynecology, Psychiatry, Medicine, Nephrology, Clinical Teaching, Neurosciences, Cardiology, Cardiovascular Surgery, Orthopedics, Hemodialysis (Kidney Transplants), Emergency and Out-Patient Services, Active Rehabilitation Program (Adult).**

The Staff Development and Training Department offers ongoing lectures and demonstrations in addition to a 6 month diploma course (twice yearly) in—Critical Care Nursing, Neurosciences, Operating Room Nursing.

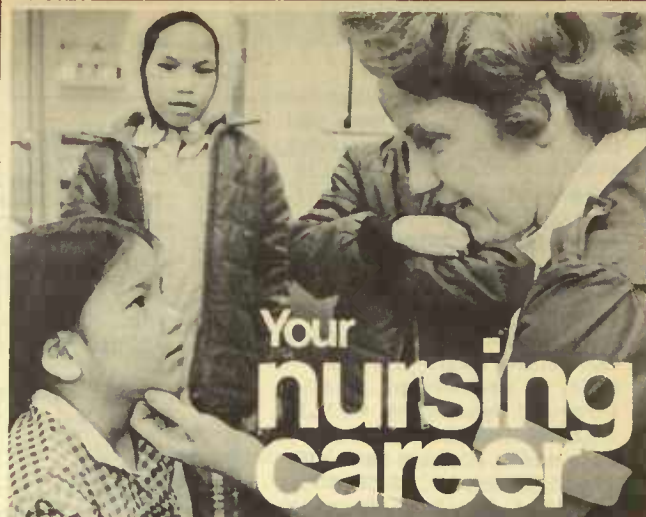
Located in St. John's, Newfoundland - the oldest city in North America with a population of 120,000, offering cultural and recreation activities in a friendly atmosphere.

Fishing, hunting, boating available approximately 10-14 miles outside the city.

For information regarding salary and other conditions of employment write or call:

Director of Nursing  
General Hospital  
Prince Philip Drive  
St. John's, Newfoundland  
A1B 3V6

Telephone No.: (709) 737-6307



## with Canada's Medical Services

When you, as a qualified nurse, join Canada's Medical Services, the door opens to **unique opportunities for a nursing career**.

Our job is to provide health care to the native people in the provinces and territories of Canada. We operate hospitals, outpost nursing stations, health centres, major clinics, occupational health units and other stations of various types from coast to coast. In the course of your career with us you can move through many of these nursing posts and **advance from staff to senior positions**, as you attain the required qualifications and demonstrate your ability.

You may sometimes be located in remote areas where **self-reliance** and **good judgment** are needed — with the nearest physician a telephone call away. But you always have the support of senior nursing and medical personnel, both "on call" and on "routine visits".

In addition to your salary, there are special allowances and benefits such as travel expenses, overtime compensation, isolation post allowances, superannuation and holidays, plus the opportunity to see distant parts of Canada.

When you join our team you can be sure that you will be providing a **very important professional service** that fills a vital need for those you help. If you would like further information, mail coupon below.

Nursing Advisor  
Human Resource Planning  
Medical Services Branch  
Department of National Health and Welfare  
Ottawa, Ontario K1A 0L3

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CITY \_\_\_\_\_

PROV \_\_\_\_\_ CODE \_\_\_\_\_



Health and Welfare  
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Santé et Bien-être social  
Canada

# Canada





Immediate openings for qualified RN's on all shifts, full time, part time. 203 bed JCAH accredited acute care hospital, adjacent to Oregon Institute of Technology, offering a 2 + 2 AD/BSN program. We are located in Southern Oregon. Excellent year 'round outdoor activities. Family oriented community. Excellent working conditions and benefits. Competitive salary with opportunity for advancement. Contact Personnel Department, MERLE WEST MEDICAL CENTER, 2865 Daggett St., Klamath Falls, OR 97601, or call COLLECT (503) 882-6311, Ext. 131. We are an equal opportunity employer.



Foothills Hospital  
Calgary, Alberta

Offers the  
Following  
Five Month Post  
Graduate Courses

#### Advanced Neurological & Neurosurgical Nursing

This course serves as an extension of basic knowledge of neurological problems gained in an under graduate program. Instruction proceeds from normal to abnormal. Opportunities are provided to study and care for persons of all ages who have had an interruption in neurological function.

#### Advanced Neonatal Nursing

This course allows the nurse to gain knowledge and expertise in the Intensive Care Nursery setting. An overview of life as well as experience in related settings are also included.

Applications must be completed three months prior to the enrollment dates of March and September.

For information and application write to:  
Educational Services  
Department of Nursing  
Foothills Hospital  
1403 - 29th St. N. W.  
Calgary, Alberta T2N 2T9



## The Izaak Walton Killam Hospital For Children

### Staff Nurses

The I.W.K. Hospital for Children has vacancies for Staff Nurses on our Intensive Care Unit and Neo-Natal Unit. Must be a graduate from an accredited School of Nursing and be eligible for registration in Nova Scotia. Previous pediatric experience would be an asset.

Inquiries and applications should be directed to:

Karen Lyle  
Personnel Officer  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
B3J 3G9

## Registered Nurses

Registered Nurses are required for an 87 bed accredited Hospital in Northern Ontario.

Applicants must be eligible for Registration with the College of Nurses of Ontario.

Bilingualism is an asset.

Salary and Fringe Benefits in accordance with O.N.A. Contract.

Temporary residence accommodation is available.

Please apply in writing to:

Director of Nursing  
Sensenbrenner Hospital  
10 Drury Street  
Kapuskasing, Ontario  
P5N 1K9

## Obstetrical Supervisor

400 bed District Hospital in beautiful Georgian Bay area invites applicants from experienced Registered Nurses, with specialization in Obstetrics, for challenging opportunity in a referral District Hospital having approximately 650 deliveries per year.

Present hospital is now in the planning stages for a totally new facility by 1985.

Obstetrical Department includes a Neo-Natal Intensive Care Unit.

Qualifications: Eligible for current Ontario Registration, post RN Obstetrical preparation and experience, BScN or equivalent an asset, leadership skills, an interest in a challenging opportunity.

All inquiries are welcome. Contact:

Executive Director of Nursing  
Owen Sound General & Marine Hospital  
1201 6th Avenue West  
Owen Sound, Ontario N4K 5H3

## McMaster University Educational Program For Nurses In Primary Care

McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

Requirements Current Canadian Registration. Preceptorship from a medical practitioner. At least one year of work experience, preferably in primary care.

For further information write to:

Joan Eagle, Director  
Educational Program for Nurses  
in Primary Care  
Faculty of Health Sciences  
McMaster University  
Hamilton, Ontario L8S 4J9

## Registered Nurses

300 bed Accredited general hospital in Vancouver requires full-time, part-time and casual R.N.s for general duty and ICU nursing. Candidates should be eligible for registration in B.C. Recent nursing experience preferred. ICU candidates must have previous ICU experience.

Please apply to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C.  
V5T 3N4



## Prince George Regional Hospital

Positions available for experienced nurses or nurses interested in developing their skills in specialty nursing—Operating Room, ICU/CCU, Neonatology Nursing. Must be eligible for B.C. Registration.

- Well developed orientation program
- Inservice Education
- Expanding Operating Room and Obstetrical Suite
- 10 bed ICU/CCU

Prince George Regional Hospital is a 340 bed acute regional referral hospital with a 75 bed extended care unit and has a planned program of expansion.

For further information contact the:

Personnel Department  
Prince George Regional Hospital  
2000—15th Avenue  
Prince George, British Columbia  
V2M 1S2

## Director of Nursing Southern Alberta Cancer Centre Calgary, Alberta

The Southern Alberta Cancer Centre invites applications for this new Senior Management position for its expanding Cancer Control Programs. The Centre is affiliated with the University of Calgary and will be relocating to new facilities adjacent to a major Calgary teaching hospital in mid 1981.

Candidates will have senior nursing management experience, effective leadership and communication abilities and experience in the field on oncology nursing. A Bachelors Degree in Nursing is required and a Masters Degree preferred.

Please direct resumes in confidence to:

Director  
Southern Alberta Cancer Centre  
2104 - 2nd Street S.W.  
Calgary, Alberta T2S 1S5



## Registered Nurses

Are you looking.....  
for a challenge in your career?

Would you enjoy.....  
living in Vancouver?  
a salary range of \$1,624.00-1,784.00 per month?  
4 weeks vacation, and 100% medical-dental  
premiums?  
1 week orientation or longer for specialty areas?

If so read on!...

Shaughnessy Hospital is a major community and  
teaching facility treating the adult patient in an  
acute and long term care setting.

- We have full-time, part-time and on-call general  
duty positions available in Medicine, Surgery  
and Spinal Cord Injury Unit.
- Experienced Critical Care Nurses are required  
for our Surgical and Medical Intensive Care  
Units and the Critical Care Nursing Pool.

## Head Nurse

We are seeking a Head Nurse for our Medical  
Intensive Care Unit and Cardiac/Respirology Ward.

This position offers a challenge .... the opportunity  
to be responsible for the management of this 32  
bed area.

Clinical expertise in medical and critical care  
nursing plus previous administrative experience is  
essential.

Applicants must be eligible for registration in  
British Columbia.

Salary: \$1,868.00 - \$2,052.00 per month.

Please phone or write, detailing your qualifications  
and experience to:

Jane Mann  
Nursing Recruiter  
Employee Relations  
Shaughnessy Hospital  
4500 Oak Street  
Vancouver, B.C. V6H 3N1  
(604) 876 - 6767, local 430

SHAUGHNESSY HOSPITAL  
4500 Oak Street  
Vancouver, B.C. V6H 3N1

## OPPORTUNITY

# Alberta

## Community Mental Health Nurse — Athabasca/Slave Lake Area

Athabasca and Slave Lake are thriving farming communities  
located 100 to 150 miles north of Edmonton. We require a nurse  
to provide assessment, treatment and followup as a primary  
therapist to these communities. Other duties include provision of  
services to the communities, liaison and consultation with  
agencies.

Qualifications: Graduation from an approved school of nursing,  
eligible for nursing registration in Alberta and some related  
experience. Must have valid Alberta Driver's license and own  
transportation. Mileage costs will be reimbursed.

Salary: \$14,748 to \$17,340 (currently under review).  
Competition No. 9184-5 Open until suitable candidate selected.  
Alberta Social Services & Community Health

For detailed information, request Job Bulletins and apply to:

Alberta Government Employment Office  
5th Floor, Melton Building  
10310 Jasper Avenue  
Edmonton, Alberta  
T5J 2W4

## Newfoundland

### Public Service

## Regional Public Health Nursing Director (Public Health Nursing Supervisor II).

Western Regional Public Health Services Division, Department of  
Health, Corner Brook.

Duties: Directs a comprehensive public health nursing  
programme for the western region of the province; recruits, and  
evaluates nursing and supervisory staff; provides public health  
education services to the general public and participates in the  
implementation of regional health programmes.

Qualifications: Considerable experience in public health nursing  
including some supervisory and administrative experience;  
graduation from university with a Bachelor of Nursing  
supplemented by post graduate courses in nursing administration;  
or any equivalent combination of experience and training.

Competition number: H.PHNSII.14

Applications may be submitted in confidence to:

Public Service Commission  
16 Forest Road  
St. John's, Newfoundland  
A1C 2B9

This competition is open to both men and women.



**The International Grenfell Association  
requires  
Regional Nurses**

on permanent or short-term basis to  
work in community health centres and  
nursing stations.

Beginning salary \$15,124.00 per annum,  
with steps for education and experience.

Room and board \$126.00 per month.  
Travel arranged and paid for by Grenfell  
Association in return for one year's  
service. Apply to:

Mr. Scott Smith  
Personnel Director  
International Grenfell Association  
St. Anthony, Newfoundland  
A0K 4S0

**Royal Jubilee Hospital  
Victoria, B.C.**

Applications are invited from Registered  
Nurses or those eligible for B.C.  
Registration with recent nursing ex-  
perience.

Positions are available in all services  
of this 950 bed accredited hospital  
which includes Acute and Specialty  
Care, Obstetrics and Paediatrics,  
Psychiatry and Extended Care for  
Full Time, Part Time and Casual  
Employment.

Benefits in accordance with  
R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

**Nursing Coordinator**

Nursing Coordinator required to  
assume leadership role in an O.R./  
P.A.R. and expanding Emergency/  
Day Care suite presently under  
construction.

The applicant must have demon-  
strated leadership and administrative  
skills, post grad in O.R. and past  
experience as a Head Nurse or  
Supervisor. Must be eligible for B.C.  
Registration.

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The Battlefords Indian Health Centre is run by and for Indian people in the North Battleford District. It provides a wide range of primary care and preventive programs. We are seeking applications for the following positions.

### 1. Community Health Nurse

**Duties:** To assist the Indian people in the development of operation of a combined primary care and community health program.

Candidates should be eligible for registration in Saskatchewan and have some experience or special training in Community Health.

Previous working experience with Indian people is desirable.

### 2. Health Careers Coordinator

**Duties:** To conduct research into different health professions, educational background required for these professions, and to develop training programs in conjunction with recognized educational institutions; To act as liaison with funding agencies, Band Councils, and to provide career counselling to potential students. **Qualifications:** Completion of grade XII. Previous experience in working with Indian people is desirable. Ability to initiate and maintain working relationships with funding agencies and with training institutions.

### 3. Dental Nurse

**Duties:** To assist in providing a comprehensive dental treatment program for the Indian people in the surrounding reserves. To assist in the planning, development, and presentation of preventive programs.

Candidates should be graduates of a recognized Dental Nursing or Dental Therapy Program. Ability to work independently and as a team member. Previous experience in working with Indian people is desirable. Must have a valid drivers license.

Apply in writing to:

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**Nursing's lifeline?**

"I'm bored. I'm not stimulated. If only there was something else I could do." These are some of the comments and complaints that I've heard and thought so many times. But recently they've become more frequent and nurses are now leaving the profession to enter other fields.

Why? What is happening in nursing today that is causing members so much discontent? Shift work, increasing work loads, increasing demands of administration and doctors and supply shortages are common complaints. However, a larger issue has surfaced: continuing education. The lack of opportunity to pursue continuing education and the lack of employers who encourage or support those who desire to continue their nursing education, are posing a genuine threat to the growth of the profession.

At present, inservice education is not functioning properly. If such a program is available in a hospital, it is often scheduled during the busiest day or hour on the nursing unit. After-work classes, impromptu classes or nursing rounds during quiet times would be more appropriate.

Better use should be made of workshops and conferences. Often staff nurses' requests for professional conference leave are either refused or granted without pay, and expenses come from the nurses' own pocket.

University or college courses are not actively encouraged. For the most part, the hospital employer offers little or no financial assistance and makes no provision in a work rotation for interested nurses to attend courses. Then, after a nurse has paid to take a course and juggled her rotation in order to attend classes, she is not given a salary increment or encouraged to relate information to her peers.

School of nursing alumnae associations should offer scholarships or other financial assistance to members wishing to further their education.

Increasing technology in the hospital setting and advances in care and treatment make continuing education a must for nurses to adequately care for their patients. They need accessible, ongoing inservice programs, workshops,

conferences and courses to maintain their level of competence. If these needs are not met, will nursing become a profession of bored, frustrated people?

—Tena McLellan, RN, Ottawa, Ontario.

**Time to play our trump card**

Lately I am becoming more and more aware of nursing apathy. Needless to say, it appalls me! I pride myself in my profession and feel we should and can as nurses, evolve to greater professional heights.

When I graduated from nurses' training, I was really keen. I wanted to get out there and "practice". Sifting through all my experiences, I began to form my concept of nursing but I became disillusioned, disappointed and most of all discouraged.

Where is nursing heading? Many health professions are clammering to put definitions to their craft and consequently new disciplines are emerging. Nursing, a profession that has been around for centuries, is experiencing "the squeeze". For example, nurses used to be responsible for pre-op and/or post-op care, including respiratory functions. Then a specialty emerged — inhalation therapy. While this provided optimal care, nurses lost the role. Physicians are also suddenly discovering "new" techniques and philosophies which nurses have been using for years. They are talking about and teaching nursing!

We nurses are suppressed. Nursing schools are pushing and promoting new nursing strengths. Nursing philosophy is advocating the expanded role. Soon we are going to be backed into a corner. Unfortunately, physicians hold the power — the trump card and we are going to lose.

Why? Perhaps because we are not a totally together group. We do not have a definition of role. Do we really participate in our nursing organizations? Maybe because we are primarily females we expect to be passive and play a back seat role. Or are we downright lazy? Do we care? —Lesley Aiton Spevack, RN, N.D.G., Québec.

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# The Canadian Nurse

NOVEMBER 1980

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Drugs and people...a combination as old as recorded history. It can be therapeutic. What happens when it isn't? In this issue, a look at drug abuse from the nurse's point of view. Cover illustration by Gerry Sevier, courtesy of the Addiction Research Foundation.

# The Canadian Nurse

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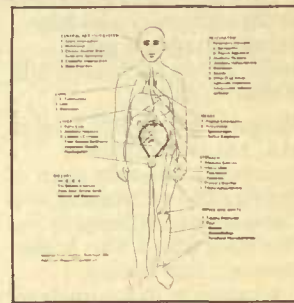
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The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-spaced. Send original and carbon. All articles must be submitted for the exclusive use of The Canadian Nurse. A biographical statement and return address should accompany all manuscripts.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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# names

Susan French, RN, BN, M.Sc., P.Ed., has been appointed associate dean, Health Sciences (Nursing) McMaster University. Formerly a CNF scholar and recipient of the Dr. Katharine E. MacLaggan Fellowship, Professor French has been a coordinator of the Master of Health Sciences Programme at the university and has helped to review grant applications for Health and Welfare Canada.

Margaret Steed, BN Admin., MA, has recently been appointed associate dean of the Faculty of Nursing, University of Alberta. Professor Steed who is also director, Continuing Education with the university, has been active in many areas of nursing education, including consultation services, curriculum, testing and research.

Dr. Margaret C. Cahoon, a professor in the faculties of nursing and medicine at the University of Toronto, has been appointed Rosenstadt

Professor in Health Research in the Faculty of Nursing. Concurrent with this award is the establishment of the Sunnybrook-University of Toronto Nursing Project, based at Sunnybrook Medical Centre, the purpose of which is to examine and test new and/or different methods of nursing through research in nursing practice.

Karen Mills, RN, BScN, MHSA, has been appointed director of nursing of the Edmonton Local Board of Health to succeed the retiring Evelyn Crookshanks. Mills, previously associate director of nursing with the board, is currently president of the Alberta Public Health Association, a member of the board of directors of the Canadian Public Health Association, a member of the Universities Coordinating Council Committee on Nursing Education and was a member of the Canadian Nurses Association Task Group on developing standards for nursing practice.

N. Patricia Barry, RN, BN, MA, has been appointed Director of Nursing of the Hamilton Psychiatric Hospital in Hamilton, Ont. A graduate of the Saint John General Hospital School of Nursing, Saint John, N.B., McGill University, Montreal and New York University, she was a clinical specialist in mental health nursing and Assistant Director of Nursing at Hamilton Psychiatric Hospital prior to this appointment.

Ginette Rodger, BScN, MN, has been elected vice president of the Board of Directors of the Canadian Council on Hospital Accreditation for the year 1980-81. Presently Director of Nursing at l'Hôpital Notre-Dame in Montreal, she will be assuming the position of executive director of the CNA, February 1, 1981.

Lorea A. Ytterberg, RN, BN, M.Sc., a graduate of St. Paul's Hospital School of Nursing, Saskatoon, Sask., McGill University and the University of British Columbia, has been appointed vice-president (Nursing) for the University of Alberta Hospitals. Formerly director of medical nursing at the Vancouver General Hospital, she has also been active as a nursing instructor and hospital planner.

The names of this year's winners of the Judy Hill Memorial Fund scholarships have been announced. Heather Blundell, a graduate of the British Columbia Institute of Technology School of Nursing, has worked as a staff nurse in Vancouver hospitals and spent one summer nursing in Resolute Bay, NWT. She is currently enrolled in the Advanced Practical Obstetrics program, University of Alberta. Patricia Gaye Hanson, a graduate of the University of Saskatchewan, has worked as a public health nurse in northern Saskatchewan. Early in 1981, she hopes to begin a midwifery course in Scotland or Australia and will then be posted to a northern nursing station.

Eleven Judy Hill Memorial Fund scholarships have now been awarded.

Recipients of the award include: Teresa Landry from New Brunswick, studied midwifery in the UK, returned to Pangnirtung, Baffin Island as nurse-in-charge, then transferred to Spence Bay, but is now returning to Pangnirtung. Beverley Ann Robson of Melfort, Sask., studied midwifery at the Simpson Memorial Hospital in Edinburgh, returned to work in Cambridge Bay, NWT and is presently nursing in northern Ontario. Jean Livingstone of Antigonish, NS, also studied midwifery at the Simpson Memorial Hospital, then worked in Rankin Inlet as charge nurse. Angela Kucinkas, studied nursing at St. Bartholomew's Hospital in London and midwifery at the Royal Berkshire Hospital in Reading, UK, then nursed in Fort Resolution, NWT. Gail MacIntyre, of New Westminster, BC, studied at the Simpson Memorial Maternity Pavillion before returning to nurse at Igloolik on Baffin Island. She is presently nursing at the Baker Lake Nursing Station. Arlene Drysdale has now completed a nursing program at Greenwich and Bexley Health Authority, England and plans to begin nursing in the NWT later this year. Diana Fenwick, an Australian nurse, studied midwifery in Sydney, then nursed with the Flying Doctor Service in northern Australia before taking up a position with Health and Welfare Canada as a nurse in Inuvik. She will be moving to Baffin Island later this year. Eleanor Nolan, who has had previous nursing experience in Ireland, Port Hope, Simpson and Goose Bay, Labrador, as well as with the Flying Doctor Service in Australia and Frobisher Bay, NWT, is completing her midwifery and outpost nursing studies at Memorial University in Newfoundland and then expects to be posted to a northern nursing station. Elizabeth Cochrane who studied midwifery at the Aberdeen Maternity Hospital in Scotland, hopes to complete her studies in community health nursing at Memorial University before finalizing her plans for outpost nursing.

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This comprehensive new text of human growth and development covers the entire life span, from conception to senescence. The book is divided into twelve parts, each representing a separate phase of development. The four major domains — biophysical, cognitive, affective, and social — are covered separately within each unit. Specific situational and maturational crises such as language development, discipline, sexuality, and death receive in-depth consideration at the most critical developmental phase. A separate unit on the family and thorough treatment of normal physical development throughout the life cycle differentiate this book from the traditional human development texts and enhance its applicability to today's nursing curriculum.

Little, Brown. 960 Pages.  
Illustrated. 1980. \$23.95

★ 1980

## 2 NURSES' RESPONSES TO PATIENTS' SUFFERING

By Joel R. Davitz, Ph.D.; and Lois A. Davitz, Ph.D.

This is the concise, easily readable version of the authors comprehensive research report, focusing on the factors that influence the varied reactions of nurses to the pain and psychological distress of different patients. The authors clearly show how nurses are affected by their patients' age, sex, socioeconomic class, ethnic and religious backgrounds and also by their own background characteristics. Many examples illustrate how nurses' perceptions and beliefs affect their behavior with patients.

Springer. 160 Pages. 1980. \$15.50

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## 3 MATERNITY NURSING, 14th Edition

By Sharon R. Reeder, R.N., Ph.D.; et. al.

Featuring expanded coverage of the numerous facets of maternity, neonatal and perinatal nursing care—with emphasis on assessment and management throughout the antepartal, intrapartal and postpartal periods—the new 14th edition of this highly regarded text begins with a philosophy of family centered care and an exploration of culture, society, maternal care and the family in a changing world. It then progresses through units on the biophysical aspects of human reproduction, reproduction control and sexuality, antepartal, intrapartal and postpartal assessment and management, maternal disorders related to pregnancy and labor, and problems of the high risk neonate.

Lippincott. 775 Pages.  
Illustrated. 1980. \$23.95

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## 4 OPHTHALMOLOGIC NURSING

By Joan F. Smith, R.N., Ph.D.; and Delbert P. Nachazel, Jr., M.D.

A thorough, systematic look at the eye: its component parts, its potential disorders, and the nurse's role in every situation of its care. The book begins with separate chapters on each anatomical sector of the eye region that scrutinize anatomy, histology, and physiology, introduce the related special diagnostic instruments and tests, and describe all the possible pathological conditions in terms of their treatment and nursing care. The authors then discuss such special topics as nursing care of the blind patient, physical assessment of the patient with eye disorders, and specific ophthalmologic nursing procedures.

Little, Brown. 302 Pages.  
Illustrated. 1980. \$18.00

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## 5 INTRAVENOUS MEDICATIONS: A Guide to Preparation, Administration and Nursing Management

By Diane Proctor Sager, R.N., M.S.N.; and Suzanne Kovarovic Bomar, R.N., M.S.N.

Here is a handy two part reference designed to give the most complete coverage of intravenous equipment, techniques, management, and the drugs themselves. Part One describes the theories and techniques of the intravenous administration of drugs. Among the topics discussed are: helping the patient cope with stress; the correct technique for the insertion of the intravenous cannula; maintaining a patient intravenous line and regulating the flow rate of fluids and drugs; major complications of intravenous administration. Part Two, the Drug Information section, presents detailed information in column form on all drugs currently approved for intravenous use.

Lippincott. 560 Pages.  
Illustrated. 1980. \$19.25

★ 1980

## 6 BASIC PHYSIOLOGY AND ANATOMY, 4th Edition

By Ellen E. Chaffee, R.N., M.N., M.Litt. and Ivan M. Lytle, Ph.D.

Extensively revised, updated, and expanded, this new fourth edition of a leading text contains three entirely new chapters on the basic concepts of immunity, nutrition, and aging. The central concept of homeostasis has been reinforced throughout the entire book. Revisions include material on the physiology of muscle tissue, the central nervous system, and vascular and respiratory physiology.

Lippincott. 628 Pages.  
Illustrated. 1980. \$23.95







# YOU AND THE LAW

**"Nurse, you did this to me! It's your fault!"**

Corinne Sklar



*"I work on an oncology unit and must administer medication to patients whose skin, muscles and veins may be in poor condition because of the course of their illness and, sometimes, the side effects of chemotherapy. Although I try to be as gentle and as skilled as possible, sometimes post-injection there may be some discoloration, bruising or swelling in the site area. This is distressing for patients and sometimes they become very angry and blame me saying, 'Nurse, look what you did to me!' The patient does not remember that before beginning the course of treatment we discussed the possibility of such occurrences. Needless to say, this is also most distressing to me. Can the patient sue me? Would I be at fault?"*

This nurse is concerned that she could find herself the defendant in a lawsuit brought by such a patient even though she believes that she carried out her professional responsibilities to the patient with due diligence and care. Would a Court find her legally responsible for causing such injuries? While not specifically raised by this nurse as part of her question, the fact that many of the medications used in the treatment of oncology patients are potentially highly toxic and irritating to tissue if improperly administered should not be forgotten. As well, the side effects of these drugs can be severely debilitating and devastating to the patient both physically and psychologically. This is the harsh side of the therapeutic effort to combat, arrest and slow the ravages of the disease process.

Can the nurse be sued? Put baldly, the answer to this question is yes: where any person believes another person's negligence has caused him injury or damage, then that person has the right to bring a lawsuit against the person he alleges caused him that harm. The decision to sue or not to sue and who to sue is made by the plaintiff (the complainant), generally in consultation with his solicitor. It would be usual in such circumstance for a patient who decides to commence such a lawsuit to name the hospital and the nurse as defendants.

Some major factors in deciding whether or not to commence such a lawsuit are the facts themselves and the likelihood of success in Court. Given the foregoing facts, would a Court find that the nurse had negligently performed her

professional duties thereby causing the harm of which the patient complains? And, because such injuries could result in a lawsuit being initiated, would the patient succeed, given the foregoing facts?\*

As in any lawsuit, the facts of the case are most important and will be a major influence in the ultimate outcome. Here the facts are sketchy; our consideration of them must be in very broad and general terms.

For a plaintiff to succeed in a suit alleging negligence, he must show that the defendant owed to him a legal duty of care. That such a legal duty exists in this nurse-patient relationship is unquestioned; nurses owe such a duty of care to their patients. However, the plaintiff must also show that the nurse failed to fulfill this legal duty and that this failure was the direct cause of the harm of which he now complains. In our example, the patient will have to persuade the Court that the nurse administered the medication negligently and as a direct result of that negligence the injuries at the site occurred. The nurse's professional performance will be measured against the yardstick of the performance of the reasonable and prudent nurse of like training and experience.<sup>1</sup> In other words, nursing expert evidence will be presented to the Court describing the techniques and methods which the ordinary, reasonable and prudent nurse of similar training and experience functioning on an oncology unit would have employed in such circumstances. In this way, the standard of care is established.

If the care given falls below this standard and there are no mitigating circumstances (for example, the patient failed to follow instructions and hence was contributorily negligent because he assisted in his own misfortune)<sup>2</sup> then the nurse would be found to have been negligent in the administration of the medication. If the evidence presented by the nurse in her defence indicates that the nursing care given meets the

professional standard of care established by the nursing expert evidence, then the nurse will not be found by the Court to have breached her duty to the patient. Her conduct will not be found to have been negligent and legal liability will not follow; the patient's suit against the nurse, given these facts, would not be successful.

## A case in point<sup>3</sup>

The plaintiff was a 44-year-old married woman suffering from cancer who had had a mastectomy and bilateral ovariectomy. The disease process continued and chemotherapy was instituted, in this case, Adriamycin® and vincristine sulfate, both of which are administered intravenously. The plaintiff suffered skin burns requiring plastic surgery to her hand following an injection. She later brought suit against her physician, alleging that the injection he administered on a certain date caused this burn.

The trial judge noted both the courage of the plaintiff and the high degree of care and concern demonstrated by the physician. He was unable to find, on the facts before him, that the plaintiff's injury was a direct consequence of any professional negligence on the part of the physician.

Both the medications involved can cause damage to tissue if there is any extravasation on administration but, in this case, vincristine sulfate was not at issue. At the time, Adriamycin was not widely used; the trial judge noted that it was a "somewhat novel" form of treatment and it was this medication that the plaintiff alleged to have been negligently administered and to have caused the damage. Adriamycin is an antineoplastic agent which can result in cardiac toxicity, bone marrow depression and hepatic impairment. The patient must be well-monitored. As well, extravasation on injection can cause severe irritation and tissue necrosis. In addition, the side effect of complete alopecia almost always occurs as well as nausea, vomiting and mucositis. The medication is usually administered into the tubing of a freely running I.V. saline solution to reduce the possibility of extravasation on injection.

The judgment described fully the procedure used by the defendant physician. The patient's arm was soaked in warm water for 5-10 minutes to raise

\*Whether the suit will be successful in Court is highly relevant because in our system of justice, the costs of a lawsuit are generally awarded to the successful party. Therefore, if the plaintiff loses he might have to bear the costs of the defendant as well as his own. In the case that follows, costs were awarded to the successful defendant.



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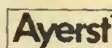
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her veins as she was fairly obese. This would increase I.V. starting facility and be more comfortable for the patient. The blood pressure cuff was inflated again to swell the vein on the back of her hand which was being used as the injection site. Then, once the I.V. saline solution was running well, the Adriamycin was injected into the Y-joint of the tubing. The physician was present constantly throughout and observed his patient, her facial expression, the site, the I.V. flow and the color of the fluid. He could recall nothing unusual occurring during that treatment. When the treatment was over, the physician applied manual pressure to the site to halt any blood flow and prevent tissue bruising.

Evidence given by the medical experts established that the physician met the standard of care applicable to a physician of similar training and experience. The trial judge stated that the highly toxic nature of the medication imposed an even higher duty upon the physician to take care, a duty the doctor met. He noted that the doctor was excessively conscious of the dangerous nature of the drug he was administering and that he took all reasonable precautions.

The trial judge dismissed the plaintiff's action. He stated that he was not satisfied that the injury was a direct consequence of any professional negligence on the part of the physician but observed that, given the novelty and toxicity of the medication, the plaintiff's action in bringing suit was a perfectly proper exercise of her legal rights.

The patient *does* have the right to sue the health professionals delivering care to him in circumstances such as these. Whether or not he succeeds depends on the facts. Is defensive nursing necessary? If the nursing care you deliver is truly professional, sensitive and caring, the answer is most probably "no".

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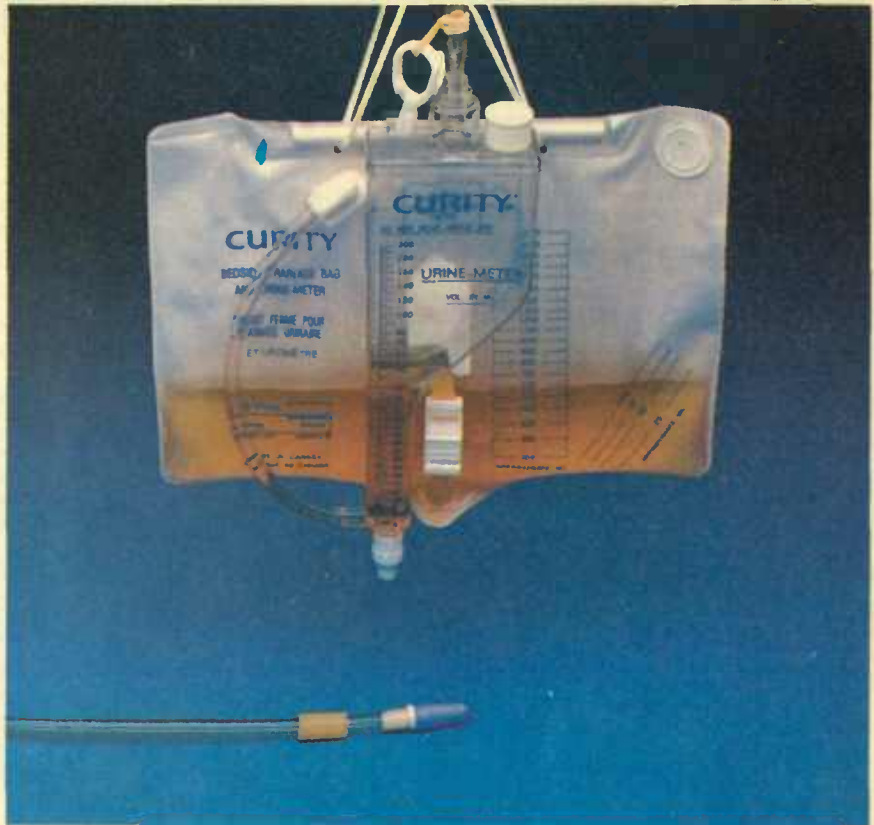
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\*Not verified

Author Corinne L. Sklar is a lawyer and practices law in Toronto, Ontario. She is legal counsel with The Imperial Life Assurance Company of Canada. Prior to her law studies, she obtained her BScN and MS degrees in nursing from the University of Toronto and the University of Michigan respectively.

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N-acetylcysteine as an antidote in acetaminophen overdose is recommended. However, its use at present is considered experimental. More detailed information on the treatment of acetaminophen overdose, including the availability of N-acetylcysteine, the preparation of N-acetylcysteine for administration as an antidote, recommended dosage regimen and acetaminophen assay methods is available from JOHNSON & JOHNSON Limited/Limitée, 890 Woodlawn Road West, Guelph, Ontario N1H 7L4, or contact your nearest Poison Control/Information Centre.

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## SPECIAL REPORT ; DRUG ABUSE

Drugs work in subtle ways, changing the way we look at the world around us, how we relate to our friends and family and sometimes even the decisions we make. Prepackaged solutions to everyday problems, drug misuse or abuse can threaten our parents, our children and even ourselves. This month CNJ takes a closer look at the problem of drug abuse and the possibilities for prevention.

Most of the contributions to this issue have come from nurses on the staff of the Clinical Institute of the Alcoholism and Drug Addiction Research Foundation, an agency of the provincial government of Ontario. Affiliated with the University of Toronto, the Clinical Institute, the Foundation's major resource for clinical research, treatment and education in the field of alcohol and drug dependence, is a 63-bed hospital with a multi-disciplinary staff representing medicine, nursing, occupational therapy, physiotherapy, pharmacy, psychiatry, psychology and social work. Facilities for assessment, outpatients, inpatients and emergency treatment allow for the provision of research-based treatment programs for persons suffering from physical, social and psychological problems associated with the use of alcohol and psychoactive drugs. Similar foundations, commissions or government departments are present in all provinces. They're there to help you!



**Joanne M. Shaw, RN** (Saint John General Hospital School of Nursing) BN (University of New Brunswick), was unit coordinator of the Clinical Research Unit, Addiction Research Foundation when this research was conducted. When she wrote this article she was coordinator of nursing services Clinical Institute, Addiction Research Foundation, a position she still holds.



**Gregory Kolesar** completed his BA degree in psychology at Temple University in Philadelphia and received his RN training at George Brown College in Toronto. When the article was written, he was working as project manager on the Clinical Research Unit of the Addiction Research Foundation.



**Mary Lourdes S.V. Gaerlan, RN, BScN**, is a graduate of the University of St. Thomas in Manila, has a certificate in Nursing Education from the University of Toronto and is a candidate for a Master's Degree in Counselling Psychology at the Alfred Adler Institute in Chicago.



**Eileen Fitzpatrick** is a graduate of St. Michael's School of Nursing. For the past two years, she has been employed as a staff nurse on 4 South at the Addiction Research Foundation.



**Gwen Casselman, RN**, has specialized in the field of drug dependency for the past ten years and is currently the nursing coordinator of a clinical research program for younger drug users at the Addiction Research Foundation.



**Kathy Chater, RN**, has worked for the Addiction Research Foundation for the past thirteen years. She is presently nursing coordinator in the Emergency Department. Kathy is a graduate of Toronto Western Hospital.



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### Adverse effects

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...on the gastrointestinal tract<sup>7,8</sup>

...during pregnancy<sup>9-11</sup>

...of concomitant use with other drugs<sup>2b</sup>

...on the blood<sup>5,6</sup>

...resulting in iron-deficiency anemia<sup>5,12</sup>

## **TYLENOL\*** side effects acetaminophen (at normal doses)

Hypersensitivity in rare instances<sup>13,14</sup>

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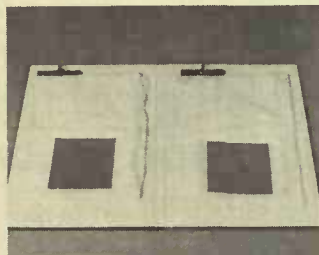
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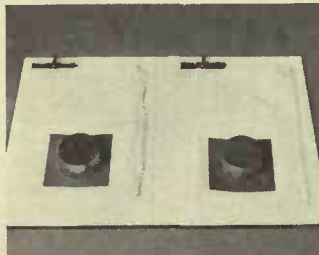
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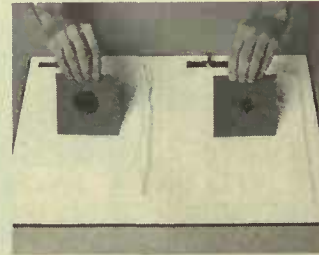
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# perspective

## A HEALTH-ORIENTED APPROACH

Gail Paech

What can we, as health professionals, do to increase society's ability to help alcohol and drug-hurt people?

Our first concern, of course, is with our clients. We must ensure that the care we provide to them is humane, effective and based on appropriate and up-to-date research findings. Since the "typical alcoholic or drug abuser" does not exist, this care must also be client-centered.

It is up to us to ensure that each one of our clients understands that the *use* of drugs carries with it the potential for *misuse*, that responsible use means controlled use, at levels which keep the benefits as high and the risks as low as possible.

To do this, we need to mount vigorous education programs that encourage each individual to choose behavior alternatives resulting in the healthiest possible lifestyle, a life that is as close as possible to being problem-free. It is important also for us to add positive reinforcement to decisions our clients may have already made about adopting a healthier lifestyle. At the same time, we must try to make sure that each individual receives scientific, factual information he can understand and which will help him to understand and support relevant changes in social policy.

This November issue of *The Canadian Nurse* marks a special effort to sensitize nurses to the problems associated with substance abuse, problems that affect an estimated 15 - 20 percent of the patients we care for. With numbers like this, obviously we can no longer leave it up to others to find the solution. Nurses have a unique responsibility and obligation to learn to identify and assist anyone who is experiencing problems related to substance abuse and, at the same time, to promote prevention strategies that will help these clients to adopt healthier lifestyles.

Many substances are addictive — tobacco, heroin, flurazepam (Dalmane®), cocaine, diazepam, (Valium®), codeine, among others — but the majority of drug problems that nurses encounter relate to the use of alcohol.

In the 13-year period between 1960 and 1973, the industrialized countries of the world experienced a more than 43 percent increase in the amount of alcohol consumed by the general population. Why do we drink more today than our grandparents drank yesterday? Several reasons come to mind:

- increased availability, including more drinking facilities, more retail outlets
- more liberal legislation, including lowered drinking age
- a decline in the real price of alcohol and
- disappearance of the counteracting effect of temperance laws.

With increased consumption has come an increase in alcohol-related problems, both social and medical, including damage to physical and psychological health, poor work performance, disruptions to family life, financial crises and difficulties with the law.

What can nurses do to help? In the past, attention has focused on the idea that the trouble lay with the 'victim'. The moralistic concept of the alcoholic (victim) as sinner has given way to the illness-oriented concept of the alcoholic (victim) as a sick person suffering from a specific disease, one symptom of which relates to alcohol use. The patient requires empathy, support, treatment — possibly hospitalization.

Both of these 'victim' concepts reinforce the idea that the drug alcohol per se has little to do with the problem. BUT excessive use of alcohol and the problems that this misuse and abuse create are clearly health issues. As health professionals, we must develop programs designed to prevent alcohol abuse that are effective and meet with public support.

Recently, there has been a revival of interest in control policy as potentially important preventive strategy. Controls tend to focus on society-at-large, rather than on individuals, a focus consistent with the research finding that relates levels of alcohol consumption in the general public to the overall health of the population. Some people argue that such controls constitute a curtailment of individual freedom but relaxing controls on alcohol as has been done in recent years indicates to many people that drinking alcohol in increasing quantities is *not* harmful, an assumption that those of us who work with alcoholic patients and their families recognize as false.

Investigation indicates that two of the most important factors in determining how much alcohol a person consumes are first, cost and second, availability. It would seem reasonable then to assume that, in the interests of health, there should be no further liberalization of control measures and that the price of alcohol should bear a reasonably constant relationship to the consumer price index. No control policy by itself is going to provide all the answers. What we need is a health-oriented, integrated approach that combines an effective control policy with preventive education and knowledgeable methods of treatment. Nurses cannot resolve the problems of drug dependence alone but, without their commitment and involvement in the promotion of healthier lifestyles, society will continue to pay the high costs associated with the abuse of these chemicals. ♣



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## USE? OR ABUSE?

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Ian W.D. Henderson

The term 'substance abuse' implies not only a philosophical stance, but also a concept of the problem of drug use that relates to dependence on a variety of chemical entities — 'social lubricants' such as caffeine, tobacco and alcohol, as well as numerous forms of licit and illicit drugs.

To label the problem as 'abuse' signifies of course that we regard a harmful pattern of personal use of any mood-altering agent as a phenomenon that must be strongly if not righteously discouraged. Such a stance is understandable: who can deny in the face of very substantial knowledge that overuse of caffeine ultimately is a cause of frazzled nerves and embarrassing mood changes as well as some adverse cardiovascular effects. Similarly, few would argue that in terms of a risk: benefit ratio, anything good can be said for tobacco. And very few of us could ever contend that excessive alcohol consumption is not a serious health and social problem in Canada. Nevertheless, most of us would probably still say that moderate use of caffeine is an entirely acceptable custom, that occasional use of tobacco is not particularly harmful, and that ready access to alcoholic beverages by adults is almost a fundamental right in our society. *Wise personal use is not reprehensible but harmful use is to be frowned upon.*

When we turn to drugs, however, we are not nearly so sure of ourselves. We have developed a kind of double standard of acceptability even for legal drugs. The use of barbiturates, often in combination with analgesics, to assuage tension headache is an acceptable practice but the same barbiturates used to

soften the harsh realities of a rough spot in our life is also a form of 'abuse'. We regard the use of cannabis to control severe nausea and vomiting associated with cancer chemotherapy as laudatory, but still consider even the occasional 'non-medical use' of the same drug to produce a sense of relaxation and euphoria as a form of 'abuse'.

In recent years many of us have been concerned about the widespread use of prescribed mood-altering drugs. About twice as many of these are prescribed for women as for men and this seems to be predicated by the belief of many (male) physicians that the presenting symptoms of women patients commonly have their origin in an emotional disorder. The prescribing of minor tranquilizers in Canada however is only about 60 percent as high as in the U.S.A., and the overall consumption of these drugs has decreased by about 15 percent over the past three years. Still, inappropriate use remains a widespread problem. Self-medication with tranquilizers is not only unwise, but differs little from other similar forms of drug abuse. Continued use of minor tranquilizers over a long period can and does result in some physical and psychological dependence which makes withdrawal both difficult and stressful. What is equally important is the fact that oftentimes the continual use of mood-altering and tranquilizing agents, of sleeping pills, or conversely of stimulants, masks either a medical or a social problem, or both. When this happens, these problems must be recognized and dealt with in a more realistic manner. ♣



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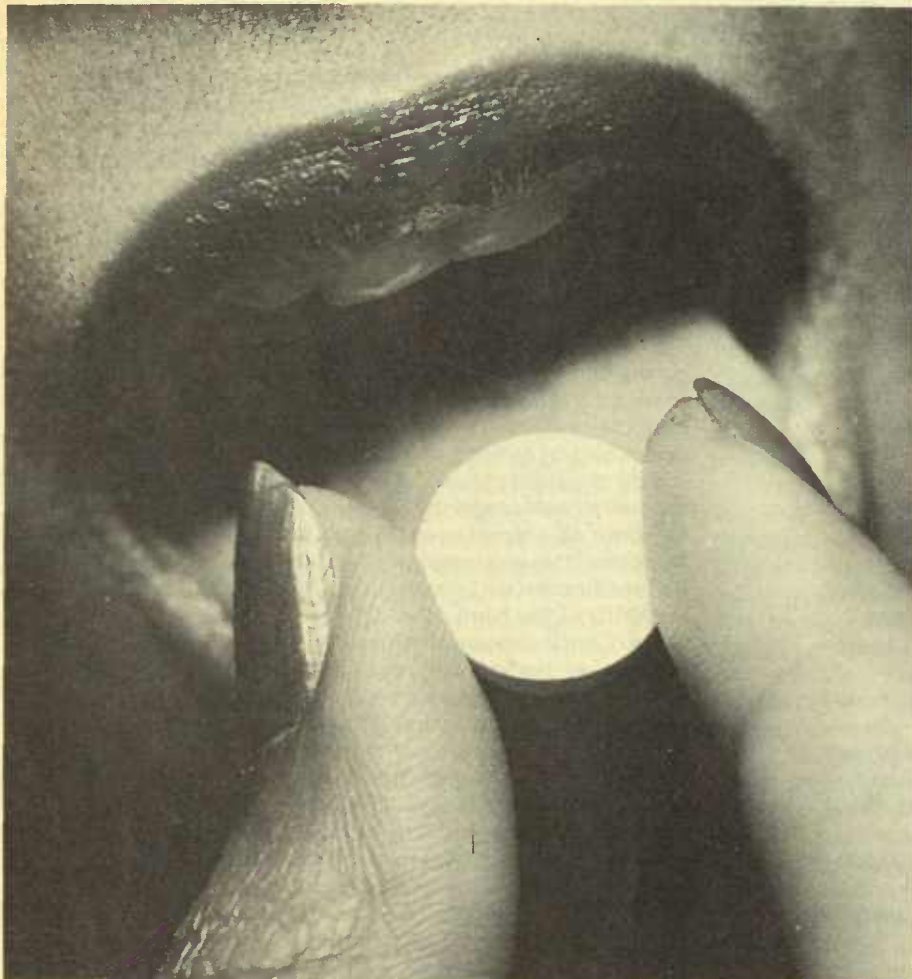


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# It could happen to you

# 1



Gregory Kolesar

Nurses, physicians and pharmacists are at greater risk for substance abuse than are members of the general population. Yet, in spite of our profession's unique training and knowledge, nurse abusers often fail to recognize and confront their own problems of drug and alcohol dependence.

The intent of this article is to increase your knowledge about nurses as substance abusers. To do this, it may help to organize information under the "five P's": the Problem, a Profile of nurses who become substance abusers, Patterns of abuse, Politics in the workplace which contribute, and a look at the Prognosis for abusers to get some help.

First of all, there is definitely a problem of drug abuse among nurses; American statistics have revealed several significant facts.

- in one study group of drug abusers, 15 percent were either nurses or pharmacists.
- there are approximately 40,000 known alcoholic nurses in the U.S.
- in one treatment center, 50 percent of the meperidine (Demerol®) abusers were RNs and doctors.<sup>1,2,3</sup>

Canadian statistics are less readily available, but using Ontario as an example the College of Nurses of Ontario heard 100 cases involving nursing "incapacity" between 1976 and 1979. These cases were a mix of alcoholism, drug abuse, and/or psychiatric illness. One hundred cases among more than 94,000 registrants might not seem like a large number, but CNO registrar Betty Secord cautions that this is "just the tip of the iceberg"; these hearings represent only the nurses who have been reported.<sup>4</sup>

## A profile

While one cannot precisely define a personality profile for alcohol-abusing nurses, Dr. LeClair Bissell, Chief of the Smithers Alcoholism Treatment and Training Center in New York, has noted some common traits. The nurses were in the upper third of their class and many had attained advanced degrees. These ambitious nurses tended to be achievement-oriented and functioned with great competence in demanding, responsible positions; more than one-third of these alcohol abusers were drug abusers as well.<sup>5</sup>

A profile for the drug-abusing nurse may be gleaned from an in-depth study conducted by Levine, Preston and Lipscomb at the National Institute of Mental Health Clinical Research Center in Lexington, Kentucky. The researchers found the average age to be 40 years, and the mean period of abuse five years. One half of the nurses abused alcohol before drugs, and 75 percent smoked cigarettes. All had undergone surgery once, and the group had an average of 6.1 surgical procedures/nurse/lifetime. During developmental years, the average number of hospital admissions was eighteen/nurse/lifetime. The authors postulate that the 90 nurses who were studied experienced a strong medical dependence in adolescence which temporarily was resolved with their choice of occupation. They suggest that these nurses sustained an unresolved dependency struggle which was the basis for their later substance abuse in adult life.<sup>6</sup>



Another study by William Lyle found that nurses "did not use drugs for kicks, but to alleviate pain or escape from reality". By 'reality', he does not mean the generalized reality of life, but rather three specific realities of physical illness, great emotional pressure, or over-demanding physical and work pressure. Thus, the profile of the nurse drug abuser is different from other drug abusers who take drugs for pleasure, to express rebellion, out of curiosity, or to be "one of the crowd". Another difference is the method of obtaining drugs; an "addict" (also typically much younger), uses black market and street drugs while the nurse more likely obtains his or hers through doctors, by forging prescriptions on stolen prescription pads, or by outright stealing from the medicine cupboard. The nurse's abuse is solitary, while other abusers usually participate in a group.

Nurses also abuse alcohol concurrently with drugs more than other drug abusers. In fact the Levine study reveals that 50 percent of their 90 drug-abusing nurses had abused alcohol first. Ironically, many nurses feel the switch from alcohol to drugs is an improvement: alcohol has a skid-row connotation, but drugs are 'medicine'. Misuse of drugs by nurses is viewed as self-administration of a therapeutic agent.

A definitive substance abuse profile hasn't been described here although certain traits do appear consistently in the population examined; not all nurses involved with substance abuse have these traits, and many with no problems do.

#### Patterns of abuse

Nurses often continue to work for years after the onset of substance abuse. They are probably too conscientious to take drugs (including alcohol) on the job at this point, but "work shrinkage" can occur. The nurse does only what is absolutely necessary and no longer welcomes challenging assignments or extra work.<sup>7</sup>

Isler has identified a pattern<sup>8</sup> which has been substantiated by several nursing administrators. As the substance abuse causes increasing problems, the nurse cannot cope with a busy active treatment area, so she switches to a slower paced unit. A switch to night duty where supervision is minimal or to a nursing home often follows. A writer in RN magazine hints at this pattern: "It's more likely that you'll face this situation on the night shift than the day shift," the author stated when writing about substance-abusing superiors.<sup>9</sup>



The next step is to *per diem* service, perhaps with a supplementary agency, because this kind of service lends itself to pilferage (a regular pattern isn't obvious) and to being absent from work without too many questions being asked. Of course, simply because a nurse works in one of the above situations, does not mean he or she is on the downward spiral of substance abuse. The variety of work situations available is one of the attractions of nursing, and a nurse who has found the workplace best suited to his or her lifestyle is ahead of the game. However, this flexibility does allow the substance abuser more time to "hide out" and to postpone the ultimate confrontation between himself and the abuse problem.

#### Politics in the workplace

Even though the nurse with a substance abuse problem says nothing and tries to hide everything, colleagues are usually aware of a problem. Co-workers notice increased absences, increased lateness, disappearances for short periods while on duty, and "work shrinkage". Personality changes including withdrawal and irritability, which are usually inconsistent with the abuser's previous affect, may appear.<sup>10</sup> The nurse doesn't always recognize that he or she has a substance abuse problem, much less what course of action to pursue and co-workers may not have much knowledge about addictions themselves, preferring to watch and wait in the hope that the addicted nurse will leave and take the problem elsewhere. They may cover up the abuser's unexplained absences or many colleagues may even give the substance-abusing nurse non-prescribed minor tranquilizers for shakiness.

Because of the staff's and supervisor's inability to face the problem and to take positive action, the connection between decreased work performance and substance abuse is avoided. Evaluation of job performance is, in fact, the only tool available to help the substance abuser in the workplace. Accusations about drinking or taking drugs will only increase denial, and the substance abuser may feel hostile. If these charges are delivered from a moralistic point of view, damage may be done to the abuser's perception of self. Undocumented charges of substance abuse could also be libelous, especially if other things are happening in the employee's life that are unknown to you. Avoid value judgments and generalizations; for example, if someone is late, he or she is "fifteen minutes late on such and such a day", not "always late because of a hangover". Action on poor job performance should come from a responsible person at least one rank above the abuser and above the reporting nurse,<sup>11</sup> however special allowances should not be made for substance-abusing nurses, especially at the expense of co-worker's feelings. If the troubled nurse has fallen asleep in the lounge, and others had to do her work, say so without rampaging or passing innuendo. The statement, "I am angry because I had to answer your lights while you were napping", is as effective as any in helping the substance abuser to realize that her abuse is affecting her professional life.<sup>12</sup>



To help the substance abuser in the workplace, document, report and confront poor job performance; accusing, ignoring, preaching, and over-support all contribute to blocking the substance abuser from the realization that he or she has a problem. Ill-informed attempts at "counseling" by inexperienced persons will certainly not help the substance abuser.<sup>13</sup>

#### Prognosis for abusers

Once a nurse realizes his or her decreased work performance or changed personal life is the result of substance abuse, help is available. Many nurses have their own counselors or family physicians but if the nurse is working for a larger institution, the employee health service can arrange for an appropriate referral. If he or she has joined a registry or has stopped working, there are the usual community supports. Many nurses do have family, friends and even strong personal resources to help them through this crisis. The most difficult task for the nurse selecting his or her own therapeutic milieu is to find an understanding therapist who is experienced in the field of substance abuse; otherwise, time will be wasted skirting around the real issues, and the nurse could merely end up with a prescription for a minor tranquilizer which will not help and could lead to cross-tolerance.

The most helpful means of treatment and support which is emerging to help all substance abusers in the workplace is the Employee Assistance Program. Such a program is meant to assist by allowing the person to seek out confidential help and by encouraging managers to identify performance problems and invite employees to seek that help. Ironically, these programs are spreading more slowly in the health care field than in industry. For example, out of more than 70 hospitals in the Toronto area, only three have EAPs. However, nursing leadership is aware of the situation and several provincial nursing associations, among them the RNAO and MARN, are looking into making employee assistance programs available to nurses.

An area of particular concern to the substance-abusing nurse is his or her licence to practice nursing. Licencing agencies exist to protect the public, but they are also there to help nurses. For instance, the College of Nurses of Ontario is typical of many licencing agencies in its efforts to help the substance abuser; if the nurse-patient maintains treatment, the licence will be

suspended until treatment is finished or if the nurse is attending a treatment program, the licence may not even be suspended, but have conditions attached. By way of comparison, statistics from the Colorado State Board of Nursing in 1975 show that out of 10 actions on drug abuse, only two nurses had licences revoked. There were four suspensions, and three continued nursing under active mental health care.<sup>14</sup> This example serves as an illustration of the support that seems to be available from nurse-licencing organizations.

There is a problem of substance abuse among nurses. Although there is no strictly accurate description of the typical abuser's personality — indeed, there is no 'typical' abuser — one can use observations of work habits and personality changes to help identify the nurse with a substance abuse problem. Just as important as identifying the problem is the realization that help is available. If the problem is yours, get help now; if you work with someone who has a substance abuse problem, help them to find help.

Anyone, at any time, has the potential to become a substance abuser.

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# A Learning Program in the Addictions

Arlee D. McGee

Six years ago in New Brunswick, the federal-provincial Working Group on Alcohol Problems set up a task force which in turn developed a series of information documents, *Core Knowledge in the Addictions Field*. The 12 training booklets function both as a publication and as a learning program, presenting up-to-date information and research on addiction.

The program is currently being offered to all workers in the alcohol and drug field in the Atlantic Provinces; in New Brunswick, for example, 15 out of 25 nurses working in this field are taking the course. A certificate of achievement is awarded on completion of the program along with 10 continuing education units from St. Francis Xavier University in Antigonish, Nova Scotia.

The course includes discussion on the history of alcohol and drugs in Canada, federal and provincial legislation, economics — the supply and demand of alcohol and drugs, prevention and developing programs for prevention of abuse, etiology and symptomatology, and treatment, including pharmacology, ethics and research evaluation.

The program provides an excellent basis of knowledge for work in this specialized field, and familiarizes the care provider with the major issues and concepts of substance abuse and addiction.

Universities and community colleges across Canada offer courses for workers in the health care field on addiction, either within their regular sessions or as day workshops. Contact the college near you for further information.

Arlee McGee, RN, BN, is a member of the Alcoholism and Drug Dependency Commission of New Brunswick. A member of the New Brunswick Association of Registered Nurses, Arlee is presently pursuing a career as independent patient advocate, consultant in addiction counseling, and freelance writer. She is also a member of the board of the Canadian Addiction Foundation, CAF representative for the Atlantic region.



# Dangerous Equations

## Drugs and carelessness add up to danger

Kathy Chater

Every drug, whether prescription or an over-the-counter preparation, has been formulated to act a certain way in your body. When several drugs are taken together or with alcohol, they may alter each other's effects and result in a serious drug interaction.

Sometimes a drug interaction may be intentional; the use of ascorbic acid and Mandelamine® is a common example as the ascorbic acid increases the acidity of urine and potentiates the effect of the antibacterial agent. A doctor may prescribe two drugs to be taken in combination because he knows they will react in a positive way to benefit the patient.

However, unplanned drug interactions, caused by taking certain drugs together or with alcohol can result in unpleasant or even dangerous consequences. For example, if a patient who

is taking an anticoagulant on a regular basis happens to take a dose of ASA as a pain reliever, the ASA and anticoagulant may work together and cause gastric bleeding.

Anyone can mix drugs unintentionally and become the victim of a 'dangerous equation'. Check the table of common drug and alcohol interactions to make sure you or your patients are not accidentally mixing substances dangerously.

There are many more categories of drugs which have the potential for dangerous side effects — diuretics and antihypertensives, for instance. Every nurse should have some knowledge of the signs and symptoms of drug interactions to increase effective nursing intervention.

In the interest of prevention, there are a number of simple rules we can remember and pass on to health care consumers:

- Never take drugs that have been prescribed or recommended for someone else.
- Before taking any drug, read the label carefully for directions.
- Whenever your doctor prescribes a drug for you, be certain to tell him of any other drugs you are taking.
- Before taking any drug, prescription or OTC, ask your doctor or pharmacist about the effects of the drug and alcohol.
- Any drugs which produce drowsiness, uncoordination or dizziness, should never be taken if you are going to drive or operate machinery of any kind.

### DANGEROUS EQUATIONS\*

Alcohol	+	Antidepressants	may	=	Increased alcohol effects
Alcohol	+	Antihistamines	may	=	Increased alcohol effects, depression and dizziness
Alcohol	+	Pain relievers	may	=	Bleeding in the stomach or intestines
Alcohol	+	Sedatives	may	=	Increased sedative effects, depression
Alcohol	+	Sleeping pills	may	=	Dangerously depressed respiration, possible death
Alcohol	+	Tranquilizers	may	=	Increased sedative effects, depression and dizziness
Antibiotics	+	Antacids	may	=	Decreased antibiotic effects
Antibiotics	+	Sedatives	may	=	Increased sedative effects
Antidepressants	+	Antihistamines	may	=	Increased antihistamine effects, dizziness
Antidepressants	+	Cold remedies	may	=	Drastically increased blood pressure
Antidepressants	+	Sedatives	may	=	Increased sedative effects
Pain relievers	+	Sleeping pills	may	=	Dangerously increased drowsiness
Sedatives	+	Antihistamines	may	=	Increased sedative effects, decreased antihistamine effects
Sedatives	+	Tranquilizers	may	=	Dangerously increased sedative effects

\*From Health and Welfare Canada



# Gasoline Inhalation:

## A community challenge

3



Photo courtesy Health and Welfare Canada

Marie Daubert

Carol MacAdam

**Two community health nurses help a small northern settlement to face the problem of gasoline inhalation among its children.**

Two young boys died in 1976 in a small settlement in northern Manitoba from lead encephalopathy attributed to chronic gasoline inhalation. This tragedy woke the community to the realization that gasoline inhalation was a serious problem among the Cree Indian youth and children, and caused the federal government to begin an investigation.

The Medical Services branch of Health and Welfare Canada undertook

to test the serum lead levels in a group of children between the ages of five and 18. In all, 156 children were tested and of these two-thirds admitted to sniffing gas regularly — they were found to have blood lead levels in the toxic range.<sup>1</sup> Many of the remaining children said they sniffed gas at least occasionally. Thirty-five children were evacuated to a Winnipeg hospital for immediate treatment; the rest who did not require treatment were monitored closely.

It was unfortunate that it took a tragedy such as this to initiate action, but the community and the government decided steps should be taken to discourage gasoline abuse among the town young people.

Gasoline inhalation has two major implications for the future health of

children: the first is the physical effect that gasoline has on the body and the second, and perhaps most difficult to deal with, is the social disruption this form of drug abuse causes for the child, his family and the community.

The components of gasoline which pose the greatest problems for physical health are tetraethyl lead (TEL) and, to a lesser extent, hydrocarbons, whose long term effects are still unknown.

The hydrocarbons produce the immediate effects that inhaling gasoline give the user, including the initial high which simulates that of alcohol intoxication, appearing within five minutes of beginning inhalation. Other effects that users have described are: euphoria, confusion, auditory and visual hallucinations, impaired judgment, and aggressive behavior. Eventually, if sniffing continues, drowsiness and coma may ensue. The goal of the user is to maintain the 'high' just short of unconsciousness. As soon as inhalation ceases, the effects will usually wear off within an hour, although a hangover effect may persist for one or two days. Some manifestations of this hangover are tremor, headache, nausea, vomiting, mild abdominal pain, anorexia and fatigue. Increased nasal secretions and red, watery eyes have also been noted, probably as a tissue response to the chemical irritation of the fumes.

The long term toxic effects are thought to be due mainly to the TEL component of the gasoline. TEL poisoning has been shown to cause damage to virtually every organ system within the body, occurring insidiously with repeated frequent use of gasoline over a long period of time. The extent of damage varies with the individual. The symptoms of lead poisoning first appear in the nervous system as manifested in changes in orientation, exaggerated deep tendon reflexes, postural tremor, and cerebellar dysfunction (ataxia, incoordination and intention tremor). If left untreated and inhalation persists, these symptoms may progress to cause coma, convulsions and death.

Lead is deposited in the long bones of the body, and can impair the growth process in a child; research is being done on the possible relationship



between TEL poisoning and in increased incidence of spontaneous abortion and congenital abnormalities after chronic exposure.

Some generalized symptoms which may also be seen are anemia, weight loss, fatigue, anorexia and lethargy. The psychological effects that have been described include hyperactivity, behavioral problems and a possible connection to later development of psychotic disorders.

#### Working from the inside out

As is the case with any form of drug or substance abuse, gasoline inhalation poses a threat to the user's emotional health and future social relations; when a group of people are abusing gasoline, their behavior is a major social problem.

Factors apparently predisposing an individual to a drug problem include:

- low socio-economic status
- member of a minority group
- prevalence of anxiety and depression
- family disorganization
- lack of harmony in parental relationships
- social disorganization within a community
- an environment that provides few alternatives to drug abuse.

All these factors were evident to some degree in our community, probably partially because the settlement was very isolated; there were also problems of unemployment, alcohol abuse, violence and a lack of recreation facilities. Reasons given by the children when asked why they abused gasoline were boredom, sadness and depression. The 'high' made them feel good, at least for awhile.

The community leaders felt that if the larger social problems could be worked on then probably the gas sniffing would decrease. A Drop-In community center was designed and implemented through a cooperative effort between the people of the community and representatives of the federal government.

The overall objective of the program was, generally, to promote a healthier lifestyle which could be accomplished in part through the provision of recreational facilities and activities for both the children and their families. The program also included lifestyle counseling in such areas as alcohol and drug abuse, and effective parenting — general child care, supervision and discipline. The program was to be supervised by outside professionals only at the outset; the goal was to have members of the community train to take over management.

Our role as the community nurses entailed two objectives, monitoring and support. Our chief responsibility was to

monitor and assess the physical condition of the children known to be sniffing gas, and to make the appropriate medical referrals for medical treatment of lead poisoning to a hospital in Winnipeg. We took monthly and bi-monthly blood sample for lead levels in children considered to be high risk because of continued abuse, and we did neurological screening as well.

We tried to provide support for the community's efforts by becoming involved in community activities, thereby providing role models, and by assisting with the counseling activities for the children and their families at the Center.

After the program had been in operation for a period of three years, many positive changes could be perceived in the town. There was a dramatic decrease in the number of children who sniffed gasoline, in alcohol abuse and resultant violence, and an increase in parental supervision of the children. The management of the center is currently being carried out by local people and is functioning well.

The lesson learned within this community is that substance abuse when practiced on such a large scale is the result of basic social problems, and when behavior is influenced to focus on health, both physical and emotional, changes can be made.✶

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\*Not verified

Carol MacAdam, a graduate of Humber Community College in Toronto, worked as a lifestyles counselor at the Drop-In community center. She is now enrolled in the outpost nursing program at Dalhousie University.

Marie Daubert, who also worked at the center, is a graduate of Holy Cross Hospital School of Nursing, Calgary. She too is studying in the outpost nursing program at Dalhousie University. Currently both Marie and Carol are gaining clinical experience in Frobisher Bay, NWT.

#### SOMETHING NEW!

Now available from the Addiction Research Foundation is an *Education Material Catalogue* which lists and describes all material offered by the A.R.F. From pamphlets to books, from video-tapes to T-shirts, there is information on every aspect of addiction and abuse. What's different about being a female alcoholic? The pamphlet entitled *The Female Alcoholic* (16 pages, 40¢) deals with society's perception of the woman alcohol abuser, her specific guilt and stress. For teachers there are the Alcohol Education lesson plans, formulated for various age groups. Occupational health nurses will be interested in the audiotape on Employee Assistance Programs, available for \$9.00. To obtain the Catalogue, contact Marketing Services, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, M5S 2S1, or telephone collect 416-595-6260.



# Dealing with the disruptive patient

# 4



*Kathy Chater*

If you are an ER nurse, more than likely you can remember occasions when you've felt hurt, embarrassed, angry, disgusted, disappointed and/or frustrated as the result of a confrontation with a patient showing the signs of alcohol or drug intoxication. Maybe you have been the target of physical violence. How can situations like this be avoided? Here's how these nurses deal with the problem.

Physical environment is important as a therapeutic milieu. At the ARF, we have found it advantageous to physically separate medically ill patients from those manifesting behavioral effects of drug abuse. In order to give adequate nursing care to both, we have retained the standard medically equipped examination rooms and have transformed a treatment room into a 'quiet room' where we can 'talk down' our patients. By removing all furniture, carpeting the walls and floor and installing adjustable lighting, we have created an atmosphere with minimal external stimuli.

Patients who are paranoid feel much safer in this environment and staff are able to relate more effectively

than in a conventional hospital room setting. A patient who is extremely disturbed from ingesting a drug such as phencyclidine would not be left unattended in this room but patients who do not require constant supervision can be monitored via a two-way intercom system connected to the nursing station.

In dealing with the disruptive patient, empathy and confidence are crucial. The nurse always introduces herself and tells the patient what she is going to do. She understands what is happening to the patient and knows that this is a temporary state induced by the drug.

## **Contingency plans**

Our team approach fosters pre-planned contingency management. If the staff on duty in a department cannot manage a patient, they call a Code 33. Male staff from other units, the duty doctor and security all respond to the emergency, enabling the doctor in charge to inform them of the situation and receive their assistance in carrying out the necessary procedure.

If the patient is armed, the contingency plan is reversed: staff leave the area and police are called in and advised of the situation. We have found it beneficial to maintain patient care plans on patients we know present frequently with the same problematic behavior. This allows staff to be consistent in treatment and eliminates

manipulation of new or relief staff. These plans are updated to match changes in the patient's status.

If a staff member is assaulted, police are informed and, if the patient is judged sane, charges are laid. Similarly, patients who vent their hostilities by damaging the furniture or breaking windows are also charged, thus holding them responsible for their own actions and not reinforcing this type of behavior by implicitly condoning it.

Having an appropriate combination of specially trained staff on each shift makes adequate control of difficult patients easier. One very important concept is the idea that each member of the team knows he or she can request help from another member if the need arises. For example, a staff member may become aware that he cannot relate therapeutically to a particular patient: he may have had several ineffectual discussions with this patient already and feel that this is happening again, or he may feel antagonistic toward a patient because of a personal problem that is bothering him, or perhaps he simply needs a coffee break. By explaining how he feels to another team member and requesting that he take over, he is exercising good judgment. The other team member will respect this and be willing to help out. In this way, the best interests of the patient are served.

Another situation which can create upsets is in the area of prescription demands. Patients are aware that physicians are the only people to prescribe medications. In some instances, patients demand drugs as part of their treatment. Even though the nurse might be well aware that drug therapy is not warranted and a medical assessment not necessary, it is wise to make the referral to the doctor anyhow. As the doctor is in a position of authority, most clients will accept the physician's reinforcement of the nurse's assessment (drugs are not required).

## **Drug knowledge**

Familiarity with drugs — knowing which ones are most likely to be ingested, understanding dependency, the factors contributing to misuse, how drugs alter sensation, mood, consciousness or other behavioral functions, cumulative effects, tolerance, symptoms



of intoxication, overdose and withdrawal — is essential for nurses working in this area. Persons who abuse drugs often fail to provide a reliable, complete or accurate history and staff must therefore watch for and learn to spot the physiological and psychological effects of the various drugs and be alert for possible complications.

Awareness of individual drug idiosyncrasies allows the nurse to give appropriate care. The patient who presents while nursing staff are quite busy, volunteering the information that he has "just had a couple of beers and would like to talk to someone", may well be asked to take a seat for a few minutes until someone is free to talk to him. If the receiving staff member does not notice that this patient is in a much more intoxicated state than that produced by a couple of beers, that he has pinpoint pupils and is having difficulty standing or walking, she may find it necessary to call a cardiac arrest to revive the patient who actually ingested a large amount of barbiturates or narcotics, as well as the beer, prior to presenting.

#### Behavior modification

Training in behavior modification is also important in controlling disruptive behavior; staff members must understand the basic concepts of behavior analysis, why such behavior is happening, and what they can do about it. They must know how to reinforce good behavior and how to decelerate undesirable behavior, thus preventing possible violence.

When a verbally abusive patient is confronted and aggravated by an inexperienced staff member, or perhaps ignored by a staff member who feels inadequate, he feels he is not achieving his likely goal of receiving sympathetic attention; in order to achieve it, he must accelerate his abusiveness or perhaps become physically violent. Staff members should recognize that verbal abuse is often a prelude to more aggressive behavior. The most effective way to deal with this behavior is to inform the patient, using a modulated tone of voice and maintaining eye contact, that he must stop his abuse (probably swearing) if he wants someone to discuss his problem. If his abusive behavior continues, nursing personnel retire to the adjacent observation room with a one-way window, through which they can continue to observe the patient, while at the same time withdrawing all obvious attention. Usually this process will modify his behavior and he will either stop the behavior in order to talk with someone, or leave. When he stops it is most important that staff respond positively as a means of encouraging this more acceptable behavior. Disruptive

behaviors that nurses may encounter in the Emergency Department include:

- manipulation
- physical violence, either threatened or real, and
- self-destruction.

*Manipulation* can be frustrating for staff to manage and difficult to discern through assessment, depending on the degree of sophistication the patient has developed in the use of this type of behavior. If manipulation is not recognized early in the assessment and responded to sensitively but firmly, the situation may deteriorate rapidly and violence may result from not meeting the patient's demands. A staff member, faced with an intoxicated patient demanding an admission which is not appropriate after medical assessment, is in a good position to avert possible danger. If the nurse is aware that this particular patient's anxieties stem from an earlier difficult withdrawal, she can present a calm explanation of an alternative plan (probably sending the patient to a detoxification center with prescribed medication to alleviate withdrawal symptoms) that will be acceptable to the patient.

*Threats of physical violence* must be taken seriously. Although a one-to-one interaction is usually preferable since the nurse is attempting to help the patient with his problem, team effort is necessary to prevent physical harm occurring to one of its members. All new staff members should be alerted to the possibility of physical violence should the nurse be unable to defuse the situation. An observation room with a one-way window that allows other team members to observe what is happening in the reception and treatment areas is also valuable.

In conducting an interview with a patient who has threatened physical violence, the nurse should maintain some distance between herself and the patient, remaining behind the desk in the reception area and not taking the patient to the examination room until she has had the opportunity to assess for herself the seriousness of his threats. Usually, behavior of this nature is modified when the patient receives assurance that he will be given help after he calms down enough to discuss the problem. If this does not happen and the patient *does* attempt to harm the nurse, the alternative of calling a code is clearly indicated.

Sometimes, *patients threaten to harm themselves* if their demands are not met. This acting-out may be an attention-seeking gesture or they may actually be suicidal or psychotic. Patients have been known to slash their wrists, mutilate their arms or swallow a bottle of pills before anyone could intervene. If we are physically unable

to manage such a patient with the number of staff on duty, we call a Code 33 for assistance. The first doctor to respond takes charge of the treatment plan. He can order restraints if necessary, or medication. A drug screening is always done to determine what drugs are present. Once the situation is under control, a psychiatric consultation is carried out to determine appropriate disposition, for example transfer to a psychiatric facility or admission to our medical unit. Maintaining a safe environment and constant observation of such patients is essential since they may decide to leave the hospital once they are feeling better.

In order to provide an effective treatment service for disruptive patients as well as others who present, we have had to work through many conceptual changes using a trial and error process. Through clinical experience, self-examination of attitudes and feeling, training in inter-personal skills, behavior analysis and modification and updating our program policies, we have succeeded in improving the effectiveness of our intervention. ♦

#### NEED HELP?

Advice and assistance are close at hand:

ALBERTA — Alberta Alcoholism and Drug Abuse Commission, 5th Floor, Professional Centre, 10050-112 St., Edmonton, T5K 1L9.

BRITISH COLUMBIA — Alcohol and Drug Commission of B.C., Ministry of Health, Box 21, 805 West Broadway Avenue, Vancouver, V5Z 1K1.

MANITOBA — Alcoholism Foundation of Manitoba, 1580 Dublin Avenue, Winnipeg, R3E 0L4.

NEW BRUNSWICK — N.B. Alcoholism and Drug Dependency Commission, 103 Church St., P.O. Box 6000, Fredericton, E3B 5H1.

NEWFOUNDLAND — Department of Social Services, Confederation Building, St. John's District Office, Harvey Road, Box 4040, St. John's, A1C 5Y6.

NORTH WEST TERRITORIES — Department of Social Development, Yellowknife, X0E 1H0.

NOVA SCOTIA — Nova Scotia Commission on Drug Dependency, 5668 South Street, 4th Floor, Halifax, B3J 1A6.

ONTARIO — Addiction Research Foundation, 33 Russell Street, Toronto, M5S 2S1.

PRINCE EDWARD ISLAND — Addiction Foundation of P.E.I., P.O. Box 37, University Avenue, Charlottetown, C1A 7K2.

QUEBEC — Health Promotion Directorate, 450 St. Joseph Blvd. E., Montreal H2J 1J7.

SASKATCHEWAN — Alcoholism Commission of Saskatchewan, T.C. Douglas Bldg., 3475 Albert Street, Regina, S4S 6X6.

YUKON — Department of Health, Welfare and Rehabilitation, Box 2703, Whitehorse, Y1A 2C6.



# The drug abusing patient in ER

5



Kathy Chater

Not all nurses receive specific instruction during their education on the short-term management of patients who present in the Emergency Room with symptoms of drug abuse or withdrawal. Here, in chart form is a quick review of the basics of nursing management for such patients: for more detail on exact clinical signs and symptoms, see *A programmed learning package* by Marylou Gaerlan (page 35).

Abused Drug	Principle Symptoms	Nursing Actions
AMPHETAMINES	hyperactivity  general debilitation	<ul style="list-style-type: none"> <li>— administer drugs as ordered, usually diazepam</li> <li>— allow patient to rest</li> <li>— give fluids to maintain hydration,</li> <li>— monitor liver function tests</li> <li>— approach with calm, empathetic attitude</li> </ul>
HALLUCINOGENS	behavioral such as general euphoria or psychosis  (symptoms vary with specific drugs)	<ul style="list-style-type: none"> <li>— employ "talk down" intervention through one-to-one interaction</li> <li>— promote relaxation and give reassurance</li> <li>— monitor results of drug screening tests</li> <li>— observe</li> </ul>
BARBITURATES	difficult to assess since abuse is often in tandem with alcohol. Most noticeable clinical sign is drowsiness, disorientation which may progress to state of coma	<ul style="list-style-type: none"> <li>— gastric lavage on doctor's order</li> <li>— observe closely for signs of respiratory depression</li> <li>— observe for withdrawal—patient may have seizures if he is a chronic abuser</li> </ul>
OPIATES	<p>of use: alternating wakefulness and drowsiness, look of intoxication</p> <p>Heavy dose or overdose: general depressed functions</p> <p>withdrawal: cramps in stomach and leg, nausea, vomiting, irritability like a severe case of flu</p>	<ul style="list-style-type: none"> <li>— observe closely</li> <li>— establish airway, position patient on his side, suction and bag until doctor arrives</li> <li>— be prepared for cardiac arrest</li> <li>— prepare injection of naloxone (narcotic antagonist)</li> <li>— treat symptomatically; symptoms usually abate within 48-72 hours</li> </ul>



# Primary Nursing

# 6

## Treatment that works for the hospitalized drug dependent client



Eileen Fitzpatrick

Nancy G. (not her real name) is one of six full-time nurses on 4S, the 15-bed in-patient drug unit of the ARF's Clinical Institute. Her fellow workers include three small-group therapists, four attendants, a nursing coordinator and a program director. Two physiotherapists, an occupational therapist and a recreational therapist are assigned to the unit part-time. Medical coverage is provided by the Out-Patient Department and, if necessary, Emergency.

Nursing on 4S is structured on the primary care model. This includes responsibility and accountability on a 24-hour basis, planning, implementing and evaluating patient care, giving direct patient care and information sharing.

For Nancy, this means acting as primary nurse for anywhere from one to five patients, each of whom may stay

up to six weeks on the unit. When she goes on shift, she also acts as associate nurse for up to 15 clients. The drug users and alcoholics on the unit range in age from 15 to 30. Their backgrounds and experience differ widely: Mark N. is a 15-year-old high school student in trouble with his teachers and parents because of cannabis use. John F. is 27, a multiple drug user referred for treatment by the courts.

The 4S program is based on a social learning theory of behavior modification; it incorporates a multiple disciplinary approach consisting of small group sessions, relaxation training, occupational therapy, leisure skills training and a physical fitness program. Nancy's role is three-fold: (1) to facilitate her client's entry into this particular aspect of the health care system; (2) to do an in-depth medical and psychosocial assessment; and (3) to provide supportive nursing care for the duration of his stay.

### Case study

Robert S. is one of Nancy's clients. He is a 29-year-old divorced male who has been taking 500 mg of Demerol® a day for the past two years. When he is admitted, Nancy sees that he is quiet, withdrawn and visibly anxious in this new environment. She begins therefore, in conjunction with the admitting attendant, to familiarize him with the unit and to let him know what will be expected of him for the first few days. She explains the ward rules, including a description of the behaviors which will mean automatic discharge from the unit. Robert discovers that he is charged with responsibility for his own behavior and that participation in the program is also up to him.

Within 24 hours, Nancy has completed a nursing medical history and, with Robert's help, drawn up the necessary care plans. Like most clients on the unit, Robert is physically fit and able to participate in all aspects of the program. His physical complaints are minor — toothache, colds, headaches, etc.

### Assessment phase

In assessing the medical complaints of the drug-dependent client, Nancy tries to remember that these patients have probably over-learned the use of medication to deal with physical and emotional discomfort: 4S philosophy is based on the belief that drug use is a learned behavior. Many clients display a convincing set of somatic complaints in order to obtain medication. Staff do not respond to such requests with drugs, but instead assist clients to develop a repertoire of alternative responses to physical complaints learned from understanding the relationship between stress, tension and physical discomfort.

Thus, when Robert says: "I have a terrible headache. I'm getting a migraine. I can't go to the gym," Nancy responds: "I noticed you just got off the phone. Was the conversation upsetting?" She learns that Robert is upset: "I just found out I won't be able to see my children for two years" and the two of them attempt to generate ways of dealing with his tension. As a result, Robert feels his complaint is recognized. He generates possible solutions and meets Nancy's expectation of attending the gym program, deciding that by attending gym he could decrease his tension and relieve his headache.



Psychosocial assessment occurs over a four- to seven-day period, during which the team tries:

- to engage the client in a treatment process by establishing a therapeutic relationship.
- to examine the drug history, identifying patterns of drug use.
- to examine lifestyles, identifying behavior patterns directly or indirectly related to drug use.
- to identify reinforcing consequences of drug use.
- to clarify the purpose of admission by determining the clients' goals with respect to drug use and lifestyle.
- to identify areas of potential treatment focus (both medical and socio-behavioral).

Brief legal, sexual, marital and/or family histories are obtained and incorporated into the assessment if both the primary nurse and client consider them relevant. This information is obtained through interviews and written assignments.

During this time, Nancy and Robert work very closely together. The information that she obtains and the goals they set become the basis for Robert's treatment. In the assessment,

the client is given full responsibility for setting his own treatment goals. The nurse simply provides him with the necessary tools, a crucial step in fostering independence and self-determination. Naturally, the degree of success varies with the client. However, to be truly therapeutic the nurse strives to provide encouragement, support and guidance, never to be autocratic at the expense of her client's right to self-determination.

#### *On-going care*

The assessment completed, Robert is invited to attend its presentation to the 4S team. He is then randomly assigned to a small group and a small-group therapist begins to work closely with him developing strategies to meet the goals defined in his assessment.

As long as he stays on 4S, Robert will remain involved with small-group therapy. He chooses the goals he wants to work on each week and the therapist assesses how well he is achieving his goals, according to clearly defined criteria. Points are awarded for achieving goals, participation in group and assignments. When Robert receives a certain number of points, he is allowed privileges such as the right to remain in the

program and passes to leave the unit.

Although Nancy continues to assume responsibility for Robert's medical management, her contact is greatly decreased, partly because of his increased physical well-being but also because independence, self-responsibility and self-determination are measures of his success in the program.

Typically, the success of nursing care is measured by the tasks the nurse performs for her clients. On 4S, the success of nursing care is measured by the tasks that clients learn to perform for themselves. Decreased contact with clients indicates increased effectiveness of care.✚

Near the end of Robert's stay, Nancy asks: "*How are things going, Robert?*" and he replies: "*Well, I have a pass tomorrow to see a lawyer and I'm working towards re-establishing contact with my parents and children.*"

Nancy: "*I'm very pleased to hear that. How are your headaches?*"

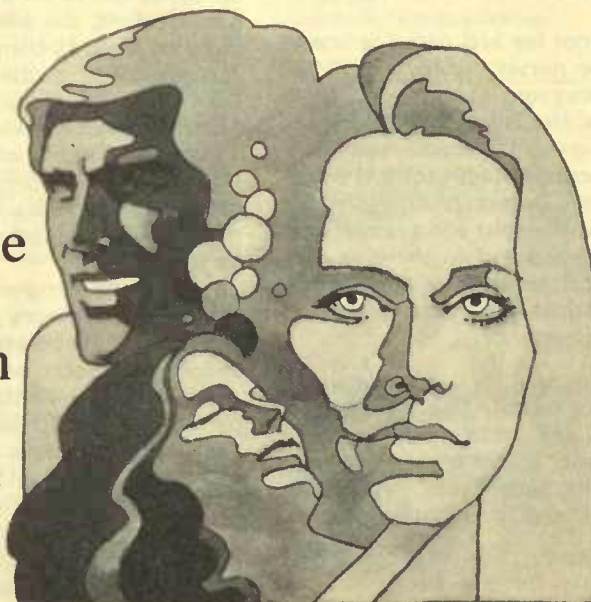
Robert: "*I haven't had one for a few days and when I get one I usually work out in the gym or use an ice pack. See you later.*"

# Breaking the cycle of abuse

# 7

Gwen Casselman

Taking drugs is a type of learned behavior. If the nurse-therapist can help the client to analyze his behavior, then together they can establish a treatment plan to which the client is committed.







### Planning

The client's position on the illness-to-health continuum is an important variable to consider in planning and implementing nursing strategies. Clients with drug and/or alcohol problems generally present in one of the following four stages:

*a) Physical crisis:* the client is acutely ill or physically injured as a consequence of drug and/or alcohol misuse. Problems might include drug/alcohol intoxication, overdose, physical withdrawal, hepatitis, gastritis, uncontrolled diabetes or injuries from falls or fights. There may be other problems not directly associated with drug/alcohol use, such as pregnancy, tuberculosis, epilepsy, a heart defect, asthma, and so on.

*b) Emotional crisis:* clients present for treatment when they can no longer cope with their fears, unpleasant memories, guilt or stress. Acute anxiety and depression are common. The request for help is often precipitated by a psychosocial crisis such as being without a place to live, arrest, deterioration of social relationships, loss of employment or death of a loved one. Often these clients choose to act in such a way (arm cutting, overdose, overwhelming physical or emotional complaints) as to guarantee help without having to overtly ask for it.

*c) Decision making:* the client thinks that he would like to change the way he uses drugs and/or alcohol because it is simply creating too many other problems for him. Many may indeed be coerced by others to seek help for their drug and alcohol taking behavior.

At this point, the idea of controlling drug/alcohol intake is just that — an idea! The client may be motivated but he is not necessarily committed to change.

*d) Rehabilitative:* The client decides to do something about his drug and/or alcohol use and seeks a specific program of treatment.

The stage or combination of stages in which the client presents often dictates the type of treatment required; as he moves through the various stages, the focus of treatment will shift from physical to emotional to psychosocial needs, to the acquisition of knowledge and skills and to the application of these in real life situations. Generally speaking, these needs are arranged on a hierarchy and one set of needs must be met before the next set can be addressed. We see the progression of planning nursing intervention according to needs in the following case history.

### Scenario

Mary Jane is an 18-year-old girl who abuses oxycodone compound (Percodan®). She presents at hospital in a tearful state, disheveled in appearance, and complains of light headedness, dizziness, nausea, vomiting and constipation. During the initial interview, the nurse learns that Mary Jane has been asked to leave her family home by her father. She does not know where to go and feels very lost and alone.

The physician says that Mary Jane needs some blood tests and some x-rays;

the psychiatrist says she needs firm support and an antidepressant; the psychologist says that she needs to get rid of the unconscious desire to punish herself; the social worker says Mary Jane needs to improve her self-esteem. Mary Jane's mother accompanied her to the hospital and says what Mary Jane needs is a good spanking and a bath!

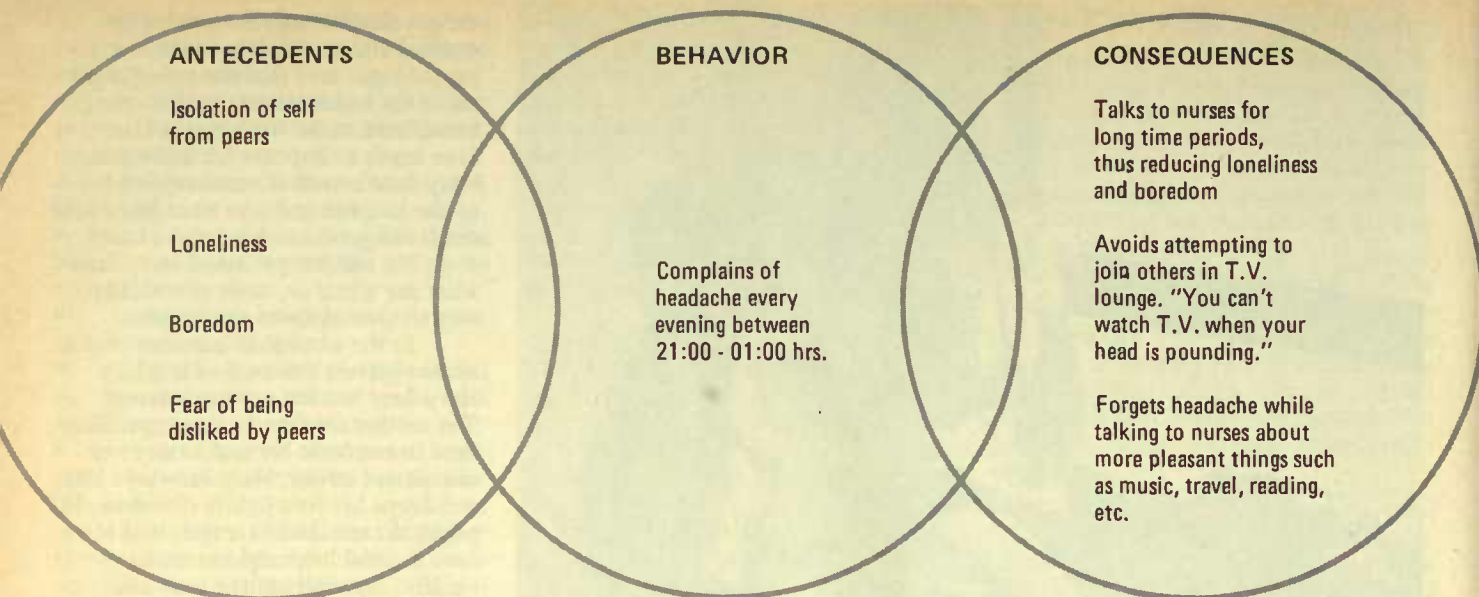
No one has yet asked Mary Jane what she wants or, more specifically, why she has come to the hospital.

In the admission interview, the nurse observes the manner in which Mary Jane and her mother interact. The mother frequently interrupts Mary Jane to confront her and to give her unsolicited advice; Mary Jane says little and keeps her fists tightly clenched. The physical examination reveals that Mary Jane is a nail biter and has muscle rigidity, especially in the neck and shoulder area. Her pulse rate and respirations are rapid but decrease to within normal limits as soon as her mother leaves the room. The nurse notes that stress is a potential problem area for Mary Jane and she identifies confrontation, advice and interaction with her mother as triggers to stress behavior. Her basic care plan stipulates that confrontation and direct advice-giving are to be avoided while Mary Jane learns alternate coping strategies.

Mary Jane's physical and emotional complaints are known manifestations of stress as well as adverse effects of oxycodone compound. The nurse shares this opinion with Mary Jane and proceeds to demonstrate a simple deep breathing exercise. Mary Jane tries it and experiences a sense of slowing down: she feels relaxed after a few breaths. The fact that Mary Jane has cooperated with this request is encouraging; it means she will probably comply with future treatment strategies, and because she has had some success, she is more likely to be committed to working on her problem. Next, the nurse assists Mary Jane to take a warm bath which further relaxes her; when she looks at herself in the mirror at the end of the admission procedure, she feels good and is ready to rest.

The first nursing action now that Mary Jane is hospitalized, is to prepare for potential physical and psychological withdrawal from oxycodone compound. The nurse keeps Mary Jane as comfortable and quiet as possible, eliminating unnecessary noise which might disrupt her rest. Mary Jane is visited regularly but not aroused which serves to reassure her of the nurse's availability while affording opportunity for observation of her physical and mental state.





The next day Mary Jane seems more relaxed; she smiles more and interacts pleasantly with staff, and there is a dramatic decrease in physical complaints. This positive behavior is reinforced, thus promoting a sense of achievement towards the goal of improved health.

#### Evaluation

The nurse begins to identify possible clues to Mary Jane's drug-taking behavior. Assessment could include a lack of assertiveness, inadequate coping mechanisms, pain, stress, frustration, fear, unpleasant memories, negative feelings about self and others or a general feeling of hopelessness.

Given that oxycodone compound is an analgesic, the manner in which Mary Jane experiences and deals with pain in hospital will provide clues as to how she misuses the drug. Nursing staff monitor any request for medication or complaint of pain, keeping in mind certain factors such as her facial expression at the time of a complaint — is it compatible with physical discomfort? Does the discomfort get better or get worse with time? Do others sympathize with her?

The monitoring process is explained to Mary Jane and she is encouraged to keep her own daily record of antecedents and consequences of complaint and request behavior.

She is asked to note situations, events, feeling states and social activities which lead to a reduction or increase in pain behavior including the taking of medication. Baseline patterns are then determined, facilitating easy recognition of any changes as Mary Jane progresses through the decision-making stage.

By studying her daily record, Mary Jane can identify a relationship between pain and stress, as well as between stress and requests for medication. She notes that stress, pain and request for medication increase before visits with her mother; in general Mary Jane's reports are congruent with staff observations of her behavior in a variety of situations.

Mary Jane has entered 'boredom' and 'feeling of loneliness' on her daily report sheets as antecedents to complaints of severe headache during the hours of 21:00 and 01:00. The nurse and Mary Jane discuss the pattern as follows:

Because Mary Jane has been practicing application of behavior analysis to common, everyday behaviors (such as putting on a sweater when she feels cold, turning up the air conditioning when she feels hot) she is able to transfer the method of analysis to her behavior in more stressful situations. She does not know how much her head really hurts when she complains but she knows that sometimes it hurts more than others.

What is clear to her at this point is that such things as boredom, loneliness and fear that others won't like her serve as cues to complain to the nurse about headache in this situation.

The talks with the nurse do make her feel better and serve as a substitute for being with the other clients; however, Mary Jane would like to watch T.V. and sometimes she would like to be with the other clients. Obviously, there is a gap between Mary Jane's present situation and where she would like to be.

Effective use of relaxation exercises, conscious thought control and assertiveness training could fill this gap. With the nurse, Mary Jane practices relaxation and imagines how she would like to present herself as she enters the T.V. lounge. She makes a list of different things she could say and practices a variety of ways to enter the room and take a seat with the nurse providing feedback. Mary Jane applies this practice the next afternoon when the T.V. lounge is less crowded; once she feels comfortable with the afternoon situation, she plans to try it during the evening hours.

#### MARY JANE'S PRESENT SITUATION

Alone in room or talking to nurses between the hours of 21:00 and 01:00

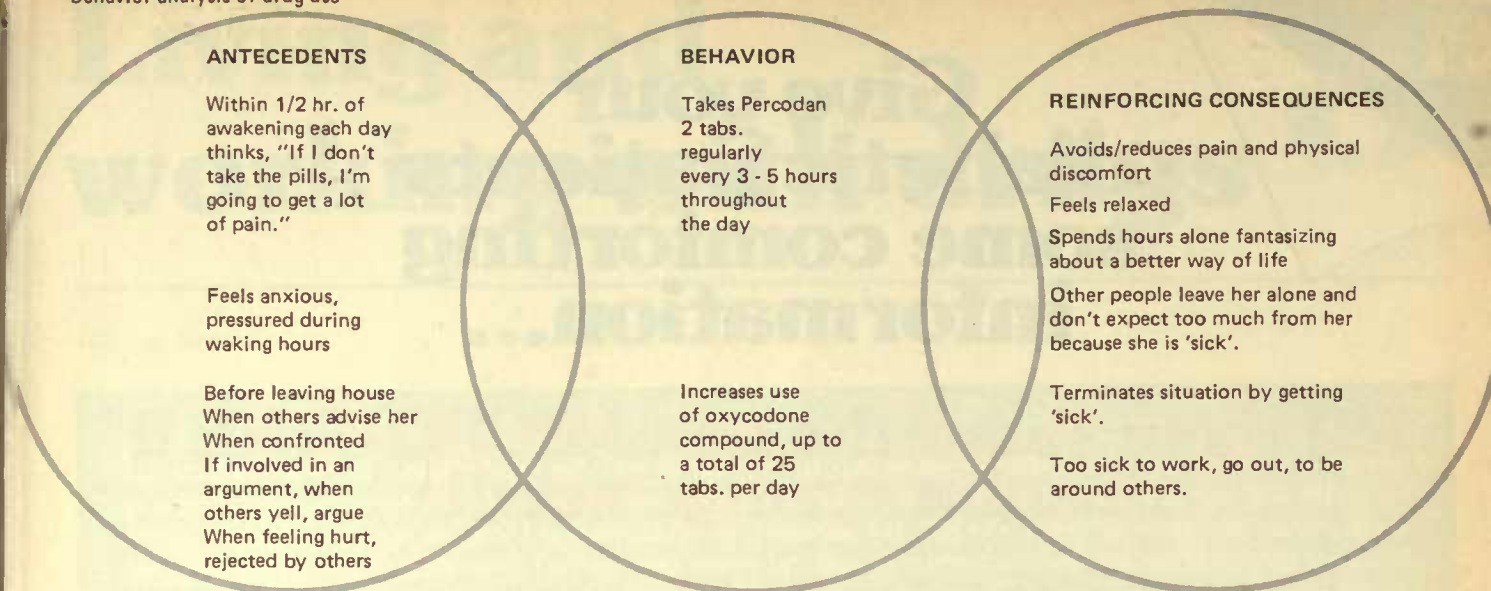
#### BLOCKING AGENTS

1. Feels anxious when she anticipates walking into the crowded room
2. Worries that others won't accept her
3. Does not know where to sit or what to say

#### WHERE MARY JANE WANTS TO BE

Sitting in T.V. room with other clients watching movies and the Johnny Carson Show





As Mary Jane starts making decisions and taking action to reduce her immediate problems, she is ready to consider her future drug use. She notices that she "looks good and is thinking more clearly". Relaxation strategies are being used successfully, not only to reduce pain but also to prevent stress in unpleasant situations — all of these factors are positive incentives to change.

#### Analysis of behavior

Mary Jane completes a behavior analysis of her oxycodone compound abuse and the nurse adds to the analysis by providing information from her observations. Then the nurse and Mary Jane meet with her mother; it is Mary Jane who explains her plans to, and shares the behavior analysis with her mother and her mother in turn adds to the analysis. She is obviously pleased with Mary Jane's progress so far.

We now have a fairly clear pattern of how Mary Jane was abusing oxycodone compound prior to admission.

This analysis demonstrates how Mary Jane was locked into a cycle of taking Percodan, not just to relieve pain, but to *avoid* pain, physical discomfort and generally stressful situations: she learned to use drugs as an avoidance-coping mechanism. Others expected less of her, consequently she did less and the entire pattern reinforced her negative feelings about herself.

The pattern created other problems for Mary Jane such as decreased mental functioning, deterioration of personal relationships,

unemployment and depression, but experience has shown that awareness of these problems associated with drug abuse is not enough to bring about a change in the abuser's behavior. They can, however, serve as incentives to change. The question to be answered then is "what fills the gap between using drugs to reduce and avoid stress and living a drug-free life *without* excessive stress?" As long as Mary Jane keeps telling herself that she can't cope, she won't. She will continue to use drugs and hope for a miracle — a man, winning a lottery, any chance to start over again. The more choices Mary Jane perceives she has in a given situation, the less likely she will be to resort to drug use. To have more choices, she has to broaden her repertoire of daily living skills. As she moves into the rehabilitation stage she defines learning to live independently of others as her general goal. This is broken down into smaller steps:

- learning self-control strategies
- abstinence from psychotropic medication
- controlled use of alcohol and over-the-counter medications
- further development and use of relaxation techniques
- social skills training (assertiveness)
- further development of problem solving skills
- learning to use leisure time constructively
- improving physical fitness.

Eventually, Mary Jane chooses a live-in program for younger drug users based on social learning principles and focused specifically on skill development. The program has a policy restricting the use of psychotropic medication which appeals to Mary Jane because she will have the opportunity to develop other ways of dealing with

physical and emotional complaints in a setting where the temptation to use drugs is minimal. Gradually, she will learn other ways of responding to the cues to use drugs. The pay-offs of her drug use were negative incentives in that she was able to avoid unpleasant situations but as she develops life skills, the need to avoid such situations will be reduced as she feels increasingly confident. Eventually, she will learn to enjoy social activities and relationships.

Long term goals for Mary Jane include improving her relationship with her parents, setting up housekeeping in her own apartment and finding suitable employment. The in-patient phase should be completed within six weeks, but the rehabilitation stage will continue beyond discharge. ♦

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# Living and working with drugs 8

Marylou Gaerlan

Do you know what "angel dust" is? The symptoms of morphine withdrawal? How "cross tolerance" affects drug consumption? A working knowledge of frequently used and abused drugs, the effect of short term or chronic use on the individual, is essential for today's nurse as chemical dependency becomes increasingly common. To help you brush up, here is a programmed learning package that will test your assessment skills. First, read through the information section provided for each drug, then with your hand covering the answers in the right hand column, read the questions and try to answer them. When you're finished, you may want to take advantage of the tearout format and save the package for future reference or pass it along to some of your co-workers.

## I DEFINITIONS

A DRUG is any substance which when taken into the body may alter one or more of its functions. Contrary to popular belief, drugs do not refer only to prescription drugs, over the counter drugs or street drugs but also social drugs. Anyone who smokes cigarettes; drinks coffee, alcohol, tea, cocoa or cola; eats chocolates or takes laxatives, antibiotics or tranquilizers has ingested a drug.

DRUG USE means consumption of a drug; a "drug user" therefore is just about everyone.

DRUG MISUSE refers to the occasional inappropriate use of either a social or a prescription drug. Having too much to drink at a party is something we condone; however, from a nursing and medical viewpoint this is unhealthy behavior and would be seen as drug misuse. Illegal drug taking is also drug misuse by virtue of its inappropriateness.

DRUG ABUSE is the use of any drug to the point where it interferes with an individual's physical and mental health or with his or her economic and social adjustment.

A drug is anything that modifies one or more functions of the body. Name three socially acceptable drugs used for recreation.

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caffeine  
nicotine  
alcohol

Mrs. Brown drinks 10 cups of coffee, smokes a pack of cigarettes a day, drinks wine at dinner, occasionally becomes intoxicated when she is worried and takes Valium® mgm prn for anxiety, but never more than prescribed. She is a:

drug misuser ( )  
drug abuser ( )

( X )  
( )



DRUG DEPENDENCE is a psychic and sometimes physical state which results from the interaction between a living organism and a drug. It is characterized by several behavioral and physical responses which include a compulsion to take the drug on a continuous or a periodic basis in order to experience its effects and often to avoid the discomfort of its absence. Many hypotheses based on the notion of an underlying character disorder that amplifies immediate gratification despite long term ill effects have been formulated in an attempt to explain the cause of drug dependency. Other circumstances that may contribute to an individual's dependence on drugs include:

- delinquent deviant behavior
- an attempt at self-medication to relieve psychic or physical distress
- a desire to enhance human faculties
- drug use as a means of achieving social acceptance
- a manifestation of a drug induced lesion
- rebellion against conventional social values
- acquired behavior, or
- socio-cultural pressures.

PSYCHOACTIVE DRUGS are those that alter sensation, mood, consciousness or other behavioral functions. All psychoactive drugs have multiple effects which depend on the dosage, one's past experience with drugs, expectations of what the drug will do, the environment in which the drug is taken, the user's age, sex, state of health, body weight, genetic complement and the presence of other drugs.

Mr. Klein is a 46-year-old man of German origin who weighs 88 kilos. Drinking a 12 pack of beer does not intoxicate him but Violet, a 22-year-old girl half his weight becomes dizzy and drowsy after drinking two glasses of wine and consuming two cold pills. What are some reasons for the different reactions of Mr. Klein and Violet?

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presence of other drugs  
genetic difference  
age  
sex  
state of health  
body weight

DRUG EFFECTS vary with time and the amount of the drug consumed. CUMULATIVE EFFECTS are produced when repeated dosages of the same drug result in an increase in the normal or expected response. ADDITIVE EFFECTS or compounding drug effects refer to the result of administering or consuming different drugs that combine to act on the same system.

TOLERANCE develops when the response to the same dose of a drug decreases with repeated use. Metabolic tolerance which refers to the body's increased ability to break the drug down and deactivate its constituents more rapidly and cell or tissue tolerance which is the adaptation of CNS cells to a substance, are the two primary types of tolerance. Other forms include: acute tolerance, seen in individuals who are frequently under the influence of alcohol or morphine and perform better as the blood levels are falling rather than rising; behavioral tolerance, a phenomenon in which frequent users of a particular drug act in a way not possible for a novice user; and cross tolerance, when an individual who is tolerant to one drug shows tolerance to another.

Alcohol compounds the effects of barbiturates.

True ( )

False ( )

( X )

( )

Mrs. Gray has to take more and more Seconals® so that she can sleep. She has developed \_\_\_\_\_.

The first time 18-year-old Susan drank a cocktail, she became dizzy. Six months later she could drink two or three without getting dizzy; she had developed \_\_\_\_\_.

Mr. White is a heavy drinker. When he had surgery, the anesthetist had difficulty putting him to sleep. He had developed:

acute tolerance ( )

cross tolerance ( )

tissue tolerance

metabolic tolerance

( )

( X )



WITHDRAWAL is the rebound image of dependence experienced when drug levels in the blood drop after a drug is withdrawn and compensatory mechanisms cause a temporary overactivity of the cells. Symptoms of withdrawal can be prevented or relieved by giving a drug which is pharmacologically equivalent to the drug from which the individual is withdrawn. This is referred to as CROSS DEPENDENCE.

Mr. Black comes to the emergency department anxious, trembling, nauseated, flushed and tachycardic. He is a known alcoholic but has run out of wine, as this is election night and all the bars and liquor stores are closed. He is suffering from\_\_\_\_\_.

An alcoholic who takes barbiturates and becomes addicted to them is said to be to the barbiturates.

withdrawal.

cross dependent

## II DRUGS AND THEIR "EFFECTS"

### A. Narcotic Depressants

MORPHINE, an opiate, is used clinically as an analgesic. Acute intoxication is manifested by a decrease in consciousness, respiratory depression, cyanosis, hypotension, pin point pupils, hypothermia and flaccid muscles. With prolonged use, a marked physical and psychological dependence develops rapidly. Tolerance to respiratory depression and analgesic and euphoric effects ensues and constipation becomes a problem. A cross tolerance to all other narcotics and analgesics also develops but will largely disappear after withdrawal.

Symptoms of withdrawal can be described within a time frame: eight to 12 hours after the last dose, lacrimation, rhinorrhea and yawning are evident; from 12 to 14 hours, a restless sleep or 'yen' may be noted; and from 48 to 72 hours following the last dose, pupils may be dilated, the individual restless, irritable and anorexic and gooseflesh skin may be evident. Generally, withdrawal from morphine results in complaining and even begging behavior, insomnia, nausea, vomiting, cramps, diarrhea, tachycardia, hypertension, weakness, hot and cold flashes, muscle spasms and 'kicking' behavior. These symptoms usually disappear in seven to 10 days.

Mr. Gray, who has had several back operations, has taken narcotics and analgesics for pain for the last two years. During his most recent admission, the pain was so severe that he was given Morphine 15 mgm every three to four hours. When he began to ask for the injection more frequently and was told to wait, he became quite abusive. Mr. Gray may have developed\_\_\_\_\_ and \_\_\_\_\_.

dependence, cross-tolerance

HEROIN (Diacetyl Morphine), a popular street narcotic, is seldom seen clinically in North America. Acute and chronic intoxication and dependence are similar to the clinical manifestations of morphine.

LAUDANUM and PAREGORIC are opium derivatives used clinically for diarrhea and dysentery. While the manifestations of intoxication, dependence and withdrawal are similar to those of morphine, they are much slower in progression and milder in nature.

DILAUDID® (Dihydromorphone, Hydromorphone) which has been largely replaced by newer drugs is still used for severe pain because of its morphine-like qualities. Clinical manifestations of intoxication and withdrawal are similar to those of morphine.

PERCODAN® (Oxycodone), a widely prescribed oral analgesic, also has symptoms of intoxication and withdrawal similar to those of morphine.

LEVODROMORAN® (levophanol tartrate) a narcotic synthetic used as an analgesic, closely resembles morphine but has a greater potency and longer duration of action.

Sally has been taking medication for pain, mostly narcotic analgesics, for about six months. One evening the pain is so severe that she takes Percodan in combination with gin. When her husband returns home and finds her unconscious, he checks her medication and determines that she must have taken 16 tablets within an eight-hour period. In addition he suspects she has also taken Aspirin® and Bufferin.®

What signs do you look for on admission?

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, and \_\_\_\_\_.

alteration in consciousness,  
respiratory depression,  
cyanosis, hypotension,  
pin point pupils, hypothermia,  
flaccid muscles



METHADONE which is used as treatment for narcotic abstinence syndromes and in maintenance therapy of opiate addicts, has symptoms of intoxication and dependence similar to those of morphine. However, tolerance develops more slowly and there is less constipating effect. Withdrawal is also like that of morphine but less intense and more prolonged, beginning on the third day, peaking on the sixth and minimal between day 10 and 16. Lethargy and anorexia may exist.

CODEINE is a mild analgesic and antitusive drug which is usually combined with ASA. Opiate dependent persons use codeine containing preparations because of their availability. Symptoms of acute intoxication are milder than those of morphine, as is withdrawal. Chronic use is manifested by tolerance, dependence and constipation.

DARVON® (propoxyphene hydrochloride), a mild analgesic is very similar to codeine but is not under the narcotic control act. Its abuse commonly begins through prescriptions, occupational contact or the illicit market.

TALWIN® (pentazocine lactate or hydrochloride) an analgesic used widely in clinical areas, is usually abused through liberal prescriptions and underestimation of its abuse potential. Acute intoxication causes sedation, sweating, dizziness and nausea; overdose is manifested by respiratory depression, hypertension and tachycardia. Chronic use results in dependence and tolerance, although tolerance develops more slowly than with most other analgesics and creates no cross tolerance with opiates. Withdrawal symptoms include abdominal cramps, chills, hyperthermia, vomiting, lacrimation and craving.

Mr. White took Talwin 50 mgm every four hours prior to and following orthopedic surgery a year ago. Now when he insists that he needs an analgesic, his doctor prescribes a placebo instead. What signs may occur as he withdraws from the drug?

abdominal cramps, chills, fever,  
vomiting, tearing, craving.

Sudden abstinence from methadone causes withdrawal symptoms in:

12-24 hours ( )  
24-72 hours ( )  
72-144 hours ( )

( )  
( )  
( X )

DEMEROL® (meperidine hydrochloride), NISENTIL® (alphaprodine hydrochloride) and LERITINE® (anileridine), are very effective short-acting oral analgesics commonly used in the clinical area and consequently abuse of these drugs usually occurs among health professionals. Respiratory depression is a sign of acute intoxication, while chronic users may anticipate tremors, twitches, dilated pupils, hyperactive reflexes and convulsions. Physical and psychological dependence develops like that of morphine but tolerance develops more slowly. Withdrawal, similar to that of morphine, but shorter, begins in three hours, peaks at eight to 12 hours and ends in three to four days, with little nausea, vomiting or diarrhea. However, muscle twitching, restlessness and anxiety are all worse than with morphine withdrawal.

You notice that meperidine is ordered much more frequently than any other drug in your supply cupboard. One day you notice that one of your colleagues is extremely anxious and restless and some of her facial muscles are twitching. What would you suspect? \_\_\_\_\_ and \_\_\_\_\_.

meperidine addiction, withdrawal



## B. Hallucinogens

MARIJUANA, HASHISH and CANNABIS (tetrahydracannabinol) have been used clinically to reduce intraocular pressure and more recently to reduce nausea and pain in terminal malignant conditions. Acute intoxication is mild with no fatal result; tachycardia, corneal congestion, dryness of the mouth, dizziness, nausea, craving for sweets, disconnected and free flowing ideas, disturbances in time perception, hallucinations, feelings of exultation, excitement and joyousness, uncontrolled laughter, sometimes panic states with delusions and distortion of reality may all result. Dependence is manifested psychosocially rather than physically and tolerance is moderate. Withdrawal occurs on the third day of abstinence and is manifested by restlessness, insomnia and dysphagia.

LSD (lysergic acid diethylamide), once used in psychiatric settings, is now most commonly seen clinically in research areas. A drug that has been abused in the streets, symptoms of acute intoxication of LSD include illusions, hallucinations, delusions and other altered states of consciousness with feelings of euphoria or dysphoria, dilated pupils, hypertension, tachycardia, tremors, nausea, piloerection, hyperthermia and muscle weakness. Chronic use results in memory impairment with extreme passivity and loss of aggression and flashbacks. Tolerance levels increase rapidly with repeated daily doses but return to normal after a period of abstinence.

MESCALINE (peyote cactus), PSILOCYBIN (sacred mushroom), ISOLYSERGIC ACIDAMIDE (mexican morning glory), DIMETHYL TREPTAMINE (DMT), and DIETHYLTRYPTIME (DET) are all much like LSD but their effects are much less potent.

MDA-34 (methylenedioxyamphetamine) combines some of the characteristics of mescaline and amphetamines. Symptoms of acute intoxication with low doses include dilated pupils, hypertension and tachycardia, while higher doses produce hyperthermia, diaphoresis and muscular rigidity. A sense of well being and increased tactile sensation are also common with low doses, with higher doses resulting in illusions and hallucinations.

DOM or STP (215 dimethoxy-4-methyl-amphetamine) is used in research and is found in the illicit market. Acute intoxication produces mild euphoria and enhancement of self awareness without perceptual distortion or hallucination.

PCP (Sernyl) an animal tranquilizer used in veterinary medicine has become a street drug known as "angel dust", "peace pill", "hog" or "horse tranquilizer". Acute intoxication with this drug varies in severity according to the dose consumed and the individual reaction. Resembling the toxic effects of stimulants, narcotics, general depressants and hallucinogens in any combination, PCP frequently produces toxic psychosis which can culminate in convulsions, coma or death. Chronic use results in anxiety, depression and flashbacks.

Since your teenage brother has come home this evening he has been laughing a lot, has eaten all of the cookies in the cookie jar, keeps rattling from subject to subject and is just not his usual coordinated self. What would you suspect he has taken?

marijuana

## C. Stimulants

TOBACCO (nicotine) has no known clinical use but its abuse is world wide. Personal, social and economic factors all influence its sustained use. Mild and temporary dizziness, nausea and weakness are considered signs of acute toxicity while chronic effects are linked to cardiovascular, pulmonary and neoplastic disease. Severe physical, psychological and social dependence usually develops, tolerance is moderate and withdrawal symptoms include craving, irritability, hyperphagia, lassitude, agitated depression and mild confusion.

COCAINE, mainly used as a local anesthetic in the past is now increasingly abused outside the clinical setting, with its use being sustained by personal and peer group pressure. Acute effects include excitement, anxiety, confusion, headache, hypernausea, vomiting and convulsions and chronic use is marked by toxic psychosis with hallucinations, delusions and paranoia. While dependence is mainly psychological, withdrawal consists of lassitude, headache and fatigue.



THEOPHYLLINE, CAFFEINE, THEOBROMINE (tea, coffee, cola drinks, cocoa) are the most popular, widely used and most socially tolerated of all drugs. Clinically the active ingredients are used as cardiac stimulants, respiratory stimulants and diuretics. Acute toxic effects consist of tension, restlessness and insomnia and chronic effects include cardiac arrhythmias, palpitation, tachycardia, diarrhea (coffee) and constipation (tea). Dependence is predominantly psychological, tolerance is moderate and withdrawal consists of headache and fatigue.

AMPHETAMINES (Ritalin®, Benezidine®, Dexedrine®, Methedrine) are used clinically for the treatment of narcolepsy and hyperkinetic children and are commonly known on the street as "speed". Acute intoxication is demonstrated by restlessness, dizziness, tremors, irritability, insomnia, euphoria, confusion, aggression, delirium, hallucinations, panic, headache, tachycardia, sweating, nausea, vomiting, diarrhea and psychotic symptoms. Chronic use predisposes toxic psychosis with hallucinations, delusions and paranoia plus weight loss and dermatitis. Both physical and psychosocial dependence are common, tolerance is very high and withdrawal symptoms come in the form of severe fatigue, lassitude, hyperphagia, prolonged sleep and depression.

Recently your mother has been complaining about being restless and unable to sleep. These complaints along with problems of constipation and occasional "racing heart", lead you to question her about her consumption of \_\_\_\_\_, \_\_\_\_\_, or \_\_\_\_\_. If you advise her to cut down her intake or abstain altogether, you should tell her to expect \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

tea/coffee/cocoa

lassitude, headache and fatigue.

Four-year-old Jimmy is hyperkinetic and has been on Ritalin® 10 mgm T.I.D. In order to encourage Jimmy to take his pills his mother has always told him that it was candy and "good for Jimmy". One day while his mother was busy in the kitchen, Jimmy busied himself in the medicine cabinet and swallowed six Ritalin® tablets. A few hours later when you receive Jimmy and his mother in the emergency department you should observe for: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

tremors, irritability, confusion, aggression, delirium, hallucinations, tachycardia, sweating, nausea, vomiting or diarrhea.

After Jimmy has been detoxified what behavior would you expect? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

lassitude, hyperphagia, prolonged sleep, depression.

#### D. General depressants

ETHYL ALCOHOL (beer, wine, liquor) is the most widely used and most abused depressant throughout recorded history. It has a wide range of clinical uses including as a solvent for other drugs and as a skin disinfectant. Acute intoxication is exhibited by a disturbance of learned behavioral controls with loss of control of mood and emotion, impaired judgment, concentration coordination, balance, speech, vision, reaction time, pain sensation and consciousness. Chronic use leads to physical and psychosocial dependency and a wide range of progressive problems including damage of the central nervous system, gastrointestinal tract and cardiovascular system. Cross tolerance with other general depressants is common. Withdrawal symptoms consist of tremulousness, nausea, weakness, anxiety, perspiration, cramps, vivid dreams, visual hallucinations, weakness, confusion, agitation, disorientation, grand mal seizures and delirium tremens.

Mr. O'Keefe, a 50-year-old man is admitted to the medical ward with a diagnosis of GI bleeding and a possible gastric ulcer. You overhear his wife saying to him "I've been telling you all these years what drink would lead to, now look what's happened". Upon further questioning you find that he has been on a 10-day-binge and had his last drink 12 hours ago. What can you expect in the next 12-48 hours? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

tremulousness, nausea, weakness, anxiety, cramps, perspiration, vivid dreams, visual hallucinations, weakness, confusion, agitation, disorientation, possibly grand mal seizures or delirium tremens.



BROMIDES (Bromoseltzer®, Nytol®, Sominex®) have been used clinically as anticonvulsant sedatives since 1857. Now available over the counter, acute intoxication is very rare but habitual users may experience impaired thoughts and memory, drowsiness, dizziness, irritability, neurological effects such as tremor and uncoordinated thick speech, an acne-like rash, anorexia, halitosis and constipation. In severe cases there may be delirium, delusions, hallucinations, mania, lethargy and coma. Psychological dependence and moderate tolerance may develop and withdrawal symptoms are similar to the chronic toxic effects.

CHLORAL HYDRATE, an hypnotic, gained fame outside the clinical arena, as the drug to be combined with alcohol to produce the "Mickey Finn". Acute intoxication mimics barbiturate intoxication; chronic use produces tolerance, dependence, gastritis, dermatitis and renal damage and withdrawal symptoms are similar to those of alcohol.

BARBITURATES (Veronal®, Luminal®, Mebaral®, Amytal®, Butisol®, Nembutal®, Seconal®, Pentothal®) are used as hypnotics, sedatives, anti-convulsants and in the case of Pentothal®, as an intravenous anesthetic. Acute intoxication mimics that of alcohol in its early stages, however, severe intoxication leads to coma, respiratory depression, hypotension, cyanosis, weak and rapid pulse and cold and clammy skin. Respiratory and renal complications and death may result from a cardiopulmonary arrest. Thick speech, nystagmus, diplopia, strabismus, ataxia, positive romberg, skin rashes, dependence and tolerance are all signs of chronic use. Withdrawal symptoms which are like those of alcohol with a somewhat greater chance of convulsions, peak on the second to third day for short acting barbiturates and on the seventh or eighth day for the longer acting drugs.

What signs would you observe for in someone who had been on prolonged barbiturate use?

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and  
\_\_\_\_\_.

thick speech, nystagmus, ataxia, positive romberg, skin rashes, diplopia and strabismus.

SEDATIVE HYPNOTICS, such as Doriden® (glutethimide) and Noludar® (methypylon), are frequently used clinically. Acute intoxication mimics that of short acting barbiturates with less respiratory depression but more hypotension and danger of circulatory collapse and physical dependence. Withdrawal symptoms are also like those of barbiturates except that there is a greater tendency towards convulsions. Withdrawal-like symptoms may also occur in individuals taking only moderate doses when dosages are reduced.

TRANQUILIZERS, such as Miltown®, Equanil® (Meprobamate) are used clinically as tranquilizers and create effects similar to barbiturates. Benzodiazepines (Librium®, Chlordiazepine), Valium® (Diazepam), Serax (Oxazepam), Dalmane® (Flurazepam) are minor tranquilizers and are the most widely prescribed of all depressant drugs. As sedatives, anti-convulsants and sedative hypnotics, they are used in the clinical management of a wide variety of conditions including alcohol withdrawal and labor. Acute toxicity is less than with other depressants but additive effects occur when these medications are used with other depressants. Elderly people are most susceptible with drowsiness and lethargy as the most common effects. Chronic use leads to tolerance, dependence, stimulation of appetite, skin rash, impaired sexual function, vertigo and menstrual irregularities. Withdrawal symptoms mimic those of long acting barbiturates.

Mrs. Barnes, the mother of a five-year-old girl and two boys, three and one, was prescribed Diazepam 5 mgm T.I.D. and 10 mgm hs, after complaining to her physician of vague aches, pains and insomnia. After taking the medication for 10 months, she returns to the clinic with the same complaints as well as dizziness, irregular periods and weight gain. She wants her prescription renewed and increased. Mrs. Barnes is suffering from:

withdrawal ( )	( )
dependence ( )	(X)
tolerance ( )	(X)
chronic toxicity ( )	(X)
acute intoxication ( )	( )

Mrs. Smith, a 78-year-old lady, was becoming quite unmanageable on the geriatric ward. Since her physician prescribed Valium 5 mgm Q.I.D., she has become quiet and sleeps most of the time, even falling asleep during mealtime. She is suffering from:

withdrawal ( )	( )
dependence ( )	( )
tolerance ( )	( )
chronic toxicity ( )	( )
acute intoxication ( )	(X)



**VOLATILE SUBSTANCES** (aerosols, commercial solvents, anesthetics) initially cause slurring of speech, loss of coordination, lessening of inhibitions, dizziness, ataxia, diplopia and tinnitus. Hallucinations, hazy euphoria, muscle spasms, marked behavioral changes and impaired perception and judgment are sometimes also experienced. As the effects wear off, the individual usually feels drowsy and nauseated and there may be alterations in consciousness from stupor to coma. Chronic use leads to tolerance, dependence, weight loss and damage to organ systems (lungs, bone marrow, liver and kidneys). Most effects, however, are reversible upon cessation of use unless the drugs abused were cleaning fluids or aerosol spray.

When emaciated 14-year-old Michael was found unconscious in the school yard, a plastic bag was found in his pocket. He regained consciousness soon after but behaved in a bizarre manner, even hitting the school nurse. The nurse suspects solvent abuse. What are the possible physiological consequences for Michael? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

damage to lung tissue, liver, kidney tissue and bone marrow.

### III PSYCHO-SOCIAL PROBLEMS ASSOCIATED WITH DRUG ABUSE

1. Avoidance mechanisms are commonly used by drug abusers in order to maintain their drug taking behaviors; deception and denial are common among middle class "hidden" drug abusers. Frequently, counseling is made particularly difficult when the addict develops the skill of manipulation, "gaming" others or "conning" them, forming an almost impenetrable wall against counseling. "Rounding", the verbal ability to avoid unpleasant subjects, especially when confronted, is another skill developed by many addicts.
2. Criminal activity, such as theft, prostitution and breaking and entering have long been associated with heroin addiction and more recently physical violence has become linked to the problem. However, there are still large numbers of addicts who do not engage in these activities.
3. Suicide is usually accidental, resulting from confusion or a semi-conscious state where the individual forgets how much of the drug he has consumed. It may also occur as a result of contamination, where the drug has been mixed with other drugs or toxic substances or may follow hallucinations and loss of judgment from "bad trips" and intoxication.
4. Child abuse is the result of an addict's inability to alter his lifestyle to accommodate children. He fails to make responsible decisions concerning the child's needs and is incapable of meeting the child's needs if it means denying his own. Consequently, the child is alternately pampered and neglected.
5. Chronic unemployment due to tardiness, constant absences and inability to perform a job occur because of intoxication and apathy while under the influence of drugs. The addicted population have a higher incidence of unemployment than the general population.
6. Family breakdown is inevitable due to the inability of the addict to maintain a close relationship by altering his own lifestyle to accommodate someone else.

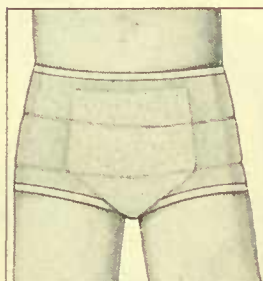
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"My utmost thanks for the interest and effort you've put into alleviating problems people like myself have been having for years."

*Ostomate  
Mesa, Arizona*





# Understanding the physiology of alcohol abuse

9

Marylou Gaerlan

*Four-year-old Johnny doesn't seem to be growing as fast as his friends, he is mentally slow, and although he is not a downright ugly child, his face just doesn't look right.*

*Mr. Peters, a 52-year-old man comes to the emergency department with frank hematemesis, his vomit smells of alcohol.*

*Three days post-op, Mrs. Fox spikes a temperature of 38.8°C. She complains that her skin feels 'crawly' and that she is having nightmares.*

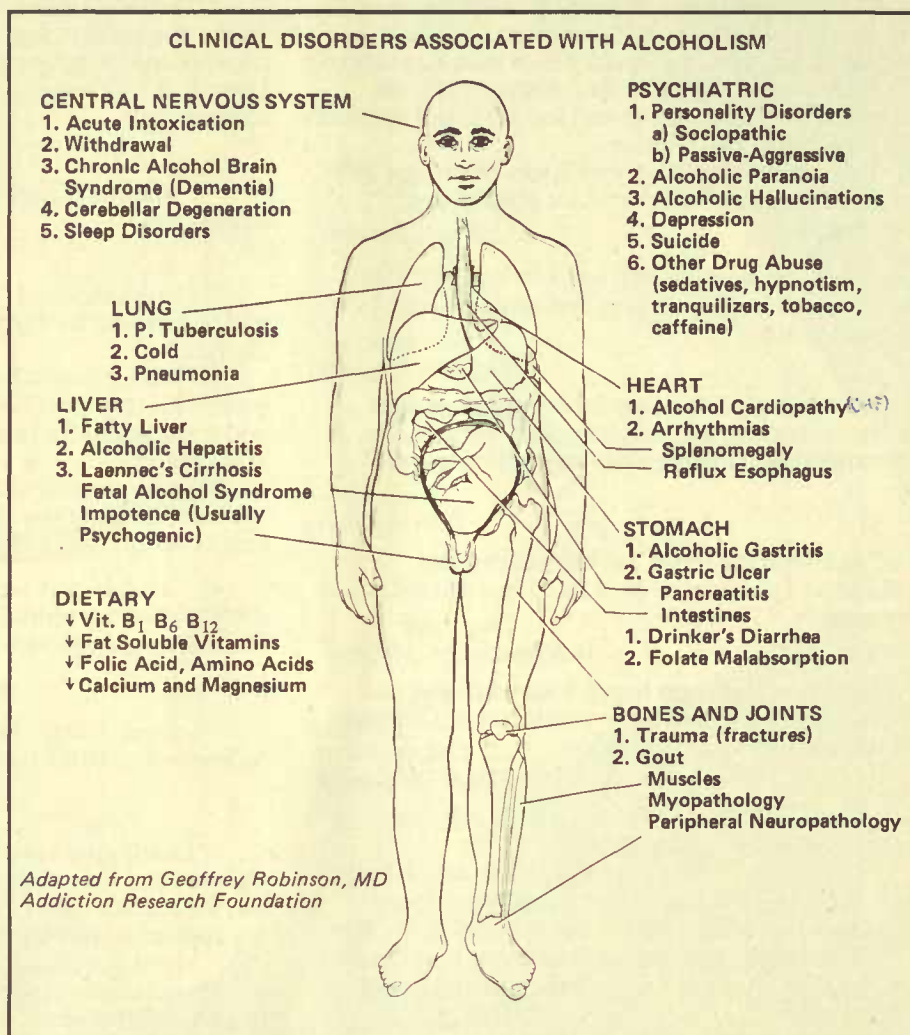
*Mr. Long, a 48-year-old man, admitted to the medical unit with a diagnosis of hepatitis, is described by his admitting nurse as having wiry telangiectasia, spider nevi and cigarette burns on his skin.*

What do these individuals have in common? All four have medical problems stemming from the physiological consequences of alcohol abuse.

Can you recognize an alcohol problem and understand its occurrence?

**Alcohol, the drug**

Alcohol or, more specifically, ethyl alcohol is directly absorbed into the bloodstream from the G.I. tract. It is rapidly absorbed from an empty stomach but the rate of absorption in this organ varies, depending on the volume, character and dilution of the beverage, the presence of food and the time taken for absorption. In the small intestine, absorption is extremely rapid and independent of the above factors. It is evenly distributed throughout the body according to the water content of the tissues involved, but more specifically in organs where there is a large blood supply, such as the brain. Since increased fatty acid esterification *in vivo* occurs with ethanol, its molecules become small enough to pass through the blood-brain barrier, making the central nervous system a veritable target.



Approximately two percent of alcohol ingested is eliminated in the breath and urine, the remainder is metabolized in the liver where the following phenomenon occurs. Alcohol dehydrogenase catalyzes a breakdown of alcohol into acetaldehyde and nicotinamide dinucleotide (NAD). Acetaldehyde is further metabolized into acetate. With the help of coenzyme 'A', acetate enters the Krebs cycle. It is eventually excreted by the lungs as CO<sub>2</sub> and the kidneys as H<sub>2</sub>O (See figure one).

The liver is capable of metabolizing one ounce of absolute

alcohol per hour without affecting the nervous system, however, a daily consumption of more than ten centilitres of absolute alcohol, that is, six bottles of beer, six 1 1/2 ounce shots of liquor or 26 ounces of wine a day increases the probability of physiological damage.

## 1. The Nervous System

Because of the vascularity of the brain and alcohol's ability to cross the blood-brain barrier, the central nervous system is especially susceptible to alcohol effects.

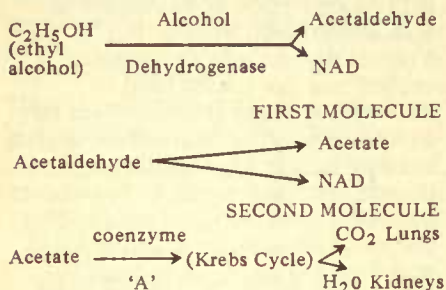
Alcohol exerts a depressant action on the polysynaptic structures of the



reticular activating system and certain areas of the cortex, particularly those parts that control integration. Therefore, taking large amounts of alcohol results in a progression of perceptual, functional and behavioral changes known as *acute intoxication*.

When the blood alcohol level (BAL) of an individual reaches 1000 mg/l, he tends to talk very loudly and his social inhibitions are reduced. With increasing BAL levels, his speech becomes progressively slurred, he begins to have mood swings and a decreased attention span, his fine motor ability

Figure one: Metabolism of  $C_2H_5OH$



is depressed, his memory becomes impaired and he assumes an unsteady gait. On physical examination, you will find a full, bounding pulse, dilated pupils and a fine nystagmus at lateral gaze.

When the BAL reaches 2000 to 3000 mg/l, the individual will exhibit tremors, ataxia, stupor, irritability and eventually unconsciousness. Death has been known to occur at a BAL of between 4000 to 7000 mg/l, depending on the tolerance level. Acutely intoxicated chronic alcoholics may also suffer from alcohol amnesia or 'blackouts', a short term memory loss lasting for about three to five minutes.

When an individual drinks 150 to 250 grams (approximately 10 drinks) of absolute alcohol daily for at least ten consecutive days and then stops, a period of hyperexcitability follows. This 'rebound' phenomenon of previously depressed nervous tissue, is known as *withdrawal or abstinence syndrome* and is considered indicative of alcohol dependence.

There are three stages to withdrawal. The early symptoms peak 24-36 hours after the last drink leaving the individual anxious, mildly disoriented, easily startled and irritable and complaining of anorexia, insomnia, tremors and 'internal shaking'. The second stage, 48 hours until up to two weeks after the last drink, is sometimes marked by grand mal seizures. Finally, the third stage brings the possibility of delirium tremens. This stage which tends to peak three days after the last drink, lasts for about three days and ends abruptly. The classical symptoms include irrationality, visual and tactile hallucinations, agitation, disorientation,

hyperpyrexia, tachypnea, hypercapnea, diaphoresis and vomiting.

*Acute brain syndrome* may occur as acute intoxication, delirium tremens or alcohol hallucinosis. *Chronic brain syndrome*, sometimes referred to as *dementia*, on the other hand, has a slow insidious onset, a progressive course and is relatively irreversible because of anatomical changes in the brain. Both acute and chronic brain syndrome present general symptoms such as alterations in memory, impaired judgment, lability, shallowness of affect and alterations in intellectual functions, including calculation, comprehension and new learning.

Chronic brain syndrome, however, is also associated with a diffuse loss of functioning brain tissue manifesting itself in behavioral symptoms. Early symptoms are fatigue, listlessness, loss of interest, depression, anxiety and personality changes such as irritability, social withdrawal, lack of consideration for others, petulance or moral laxity. These signs may be present for years and the individual may be aware that something is wrong but be unable to identify it. In the later stages there may be confusion, loss of memory for recent events and general forgetfulness with generally poor judgment. The individual may be oversensitive, exhibit psychotic symptoms like paranoia or delusions of grandeur or use other defence mechanisms such as perserveration, denial, avoidance, diversionary tactics and confabulation to avoid anxiety over functional deficits. In the terminal stage, the patient exhibits mono-syllabic speech and loss of motor and sphincter control. Death occurs from intercurrent infection.

*Peripheral neuropathy* which is commonly seen in the clinical setting is probably due to nutritional deficiencies, in particular those of the B vitamins. Initial damage is seen in the Schwann's cells which make up the neurilemma of the most peripheral nerves. As the neuropathy progresses, the conduction velocity of the involved nerve will decrease and eventually the neuron located in the spinal cord will be affected by the degenerative process. The onset of peripheral neuropathy is slow, taking from weeks to months.

The involvement is bilateral and symmetrical, starting peripherally and gradually progressing centrally. Initially there may be pain in the calf muscles or the feet, which may be associated with numbness, burning, tingling or pricking sensations of the lower extremities. Later these symptoms occur in the hands and arms, sometimes numbness of the 'stocking/glove' type occurs. As the neuropathy progresses there is muscle weakness and wasting, paralysis of the extremities, diminishing deep tendon reflexes and a wide-based foot drop

gait. Speed of recovery which is based on a treatment program of abstinence from alcohol, a nutritious diet and supplementary B vitamins, is rapid in less severe cases and decreases according to the severity of the neuropathy.

The type of *cerebellar degeneration* seen with alcoholism is unique. While no one factor has been pinpointed as a cause, it has been suggested that nutritional deficiencies as well as the effect of the high levels of acetaldehyde (the first byproduct of alcohol metabolism) on the highly sensitive cerebellum may play a role. The condition may progress rapidly, and become stabilized for years or may begin slowly at first and deteriorate rapidly during a period of stress. The clinical manifestations consist of a broad unsteady gait and stance with movement severely impaired in the dark when there are no visual cues; mild tremor of the outstretched hand, impaired coordination of fine finger movements such as writing and slow, slurred speech.

*Sleep disturbances* are a common complaint of most alcoholics, whether due to the biochemical effects of the alcohol itself or the psychological depression that frequently accompanies the condition. Basically, alcohol tends to suppress rapid eye movement (REM) sleep. The problem is reversed when the BAL drops as REM rebound occurs, causing the periods of REM sleep, dreaming sleep, to be extended. Clinically the picture presented is one of frequent waking, restless sleep, insomnia and night terrors.

## 2. Respiratory System

Chronic alcoholics are susceptible to respiratory diseases as alcohol depresses the central nervous system, thus suppressing the cough reflex and allowing the pooling of secretions. Alcohol also impedes phagocytosis and the immune response. Since many alcoholics are also heavy smokers, these problems are magnified. Commonly occurring respiratory conditions include chronic obstructive lung disease, pneumonia, pleurisy, bronchitis, emphysema and pulmonary tuberculosis.

## 3. Cardiovascular and Hematological Systems

Alcoholic cardiomyopathy is manifested primarily in the heart with little effect on the remainder of the cardiovascular system. Myocardial cells lose their integrity and leak potassium, phosphates, creatinine, creatine phosphokinase (CPK), glutamic-oxalacetic transaminase (GOT), glutamic-pyruvic transaminase (GPT) and lactic dehydrogenase (LDH). The result is depressed myocardial functioning which is usually manifested as congestive heart failure and/or arrhythmias. Earlier signs



include decreased exercise tolerance, tachycardia, dyspnea or orthopnea, edema and palpitations.

#### 4. Skeletomuscular Systems

Excess alcohol produces potassium and phosphate deficiencies thus inhibiting the use of carbohydrates by muscle cells. It also inhibits the active transport of sodium, potassium and adenosine triphosphatase. These effects may produce alcohol myopathy in the proximal muscles of the extremities, the pelvis and shoulder girdles and the muscles of the thoracic cage. In the acute stage, there is muscle pain, tenderness and edema, while in chronic cases there is no history of pain, muscle weakness progresses slowly and the individual has difficulty climbing stairs or getting up from a sitting position.

#### 5. Gastrointestinal System

Digestive problems are common among alcoholics; the following areas are affected:

- **Esophagus.** Reflux esophagitis occurs as a result of local irritation to the esophageal mucosa by alcohol and hydrochloric acid following vomiting or regurgitation. The individual with an alcohol problem is also predisposed to epidermoid carcinoma of the esophagus and esophageal varices can occur in conjunction with liver disease.

- **Stomach.** Erosive gastritis is an inflammation of the gastric mucosa resulting from alcohol ingestion as alcohol reduces the mucosal barrier leaving the stomach wall susceptible to the erosive effects of increased levels of acid. The individual displays symptoms such as epigastric distress, nausea, vomiting, distension and sometimes episodes of upper GI ulceration and bleeding.

- **Small intestine.** Malabsorption of substances including fat, xylose, folic acid and Vitamin B<sub>12</sub> are the main problems occurring in the small intestine. These conditions arise because of poor food intake, liver disease leading to a decreased storage of folic acid, a decrease in pancreatic enzyme and direct inhibition of tissue utilization of folate by alcohol.

- **Pancreas.** Pancreatitis, an inflammation of the pancreas, may be acute or chronic. Acute pancreatitis syndrome is clinically manifested by upper abdominal pain, nausea, vomiting, hypotension and an elevated serum amylase and lipase concentration. Although the exact cause of the inflammation has not been determined, some theorists speculate that: alcohol causes an increase in pancreatic secretion, spasm of the sphincter of Oddi results in an increase in pancreatic intraductal pressure, relaxation of the sphincter of Oddi allows duodenal

contents to enter the pancreatic duct or a change in the chemistry of the pancreatic juices leads to calcification and calculus formation.

Chronic pancreatitis may result from the cumulative effects of the above or perhaps the direct toxic effects of alcohol on the pancreas. The development of chronic pancreatitis is insidious, sometimes without clearcut attacks of pain, although patients may complain of chronic pain which may lead to analgesic or narcotic abuse. Signs of exocrine insufficiencies include weight loss, malnutrition and foul smelling bulky stools, often with diarrhea. Endocrine insufficiency can result in diabetes. Pancreatic calcification on x-ray and abnormal pancreatic secretion tests are classic of chronic pancreatitis. Pain is decreased with alcohol abstinence but because of its chronicity the condition is usually irreversible.

- **Liver.** As alcohol metabolism takes place almost exclusively in the liver, this organ suffers the largest portion of abuse. Alcohol flooding in the liver causes reduced glycogen formation, increased production and decreased oxidation of lipids, and changes in the structure of the liver cell. Some resultant conditions include:

- a) fatty liver, due to the increased amount of fat in the liver parenchyma. This causes liver enlargement, mild derangement of biological chemical changes (liver function tests), some nausea and abdominal pain. Frank jaundice is unusual. Alcohol abstinence completely reverses the condition both structurally and physiologically.
- b) alcoholic hepatitis is an active, inflammatory necrotizing process which involves loss of liver tissue and results in scarring and fibrosis. It may be slow and insidious in onset or acute, leading to the development of cirrhosis or death over a matter of a few weeks. Clinically, alcoholic hepatitis is manifested by hepatomegaly, jaundice, pain in the right upper quadrant, elevated temperature (102°F), marked leukocytosis and ascites. When ascites is present, the abdomen is distended with fluid, the intestines distended with air and the umbilicus is everted. Veins and white striae are visible on the abdominal wall and the renal system responds with a decrease in urine volume and an increase in urine specific gravity.

- c) alcoholic cirrhosis, also known as Laennec's cirrhosis, is seen in approximately 40 percent of alcoholics in North America. Other countries report less (England, eight percent) and others report more (France, 47.6 percent). It is marked by a disruption in the normal structure and formation of liver lobules and is irreversible as a result of the scarring process. Clinical

manifestations are similar to those of hepatitis but also include signs of portal hypertension such as shunting of portal blood around the liver and esophageal varices. Hepatic encephalopathy characterized by progressively deteriorating mental alertness, hand flapping, elevated temperature, anorexia, increased jaundice, ascites and fetor hepaticus (peculiar, sweetish odor) may become a sequela of cirrhosis.

- **Nutritional Deficiencies.** Alcohol provides calories but has no nutritional value. This, combined with the corrosive action of the chemical on the gastric mucosa and the fact that alcohol inhibits absorption of thiamine, folic acid, amino acids, Vitamin B<sub>6</sub>, Vitamin B<sub>12</sub>, fat soluble vitamins, calcium and magnesium leads to malnutrition. Signs and symptoms vary depending on what nutrients are missing but may include hyperventilation, tremor, convulsions, bizarre movements, confusion, disorientation, vivid auditory and visual hallucinations, delusions, stupor, and of course, heartburn, nausea, vomiting, diarrhea and constipation.

#### 6. The Skin

Dermatological problems encountered by the alcoholic generally result from liver damage, peripheral neuropathy and less than adequate nutrition. Premature aging, dryness and itchiness of the skin, wiry telangeiectasia (prominent capillaries), palmar erythema (liver palms), spider angiomas on trunk and face, breast enlargement in men, Dupuytren's contractures (contraction of palmar fascia causing the little finger to bend towards the palm) and bleeding gums are all typical problems of the chronic alcoholic. In some instances, a lifestyle of chronic neglect may result in pediculosis, scabies, burns, bruises and frostbite.

#### 7. Reproductive System

While prolonged alcohol ingestion may be a factor in secondary impotence, Fetal Alcohol Syndrome is now the major topic of concern in this area.

Fetal Alcohol Syndrome is caused by alcohol crossing the placental barrier from mother to fetus and may result in gross growth deficiency in the infant. Once thought to only be found in babies born to chronic alcoholic women it has more recently been determined that moderate alcohol consumption can also predispose the fetus to this syndrome and as yet no safe level of alcohol consumption during pregnancy has been identified. The infant suffering from this condition usually has a birthweight somewhat less than would be expected for his gestational age and subsequent growth is approximately two-thirds that of the normal rate. The



infant's head may be small in proportion to his body, his eyes may be undersized with shortened palpebral fissures (microphthalmus), there may be intraocular defects and ptosis of the eyelids. In the extreme case, he may have a small mid-face giving a flat lateral facial contour, there may be a cardiac septal defect and a cleft palate. The crease pattern of his hands may be altered and there may be minor joint abnormalities, pectus excavatum (pigeon-chest) and small nails. Behavioral and coordination problems are common. The child may remain chronically physically handicapped and his I.Q. may not improve with age. With these problems the child may be considered at risk for child abuse.

#### 8. Trauma and Injury

The alcoholic is prone to accidents due to intoxication. These vary from

slipping on the stairs at home and fracturing ribs to cutting a hand at work or in the kitchen; from spraining an ankle to sustaining a head injury during a fight.

#### Putting your knowledge to work

Recognizing the undiagnosed alcoholic individual requires astute assessment skills and a thorough knowledge of the disease. Yet bringing the problem out in the open is only half of the battle. The chronicity of the disease of alcoholism probably means that your patient will keep coming back. Your knowledge and understanding of what is happening to him can make his hospital stays shorter and hopefully his visits less frequent.

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\*Not verified

# AWS: recognition and rehabilitation

# 10



Gregory S. Kolesar

Joanne M. Shaw

Mr. Smith, a 45-year-old male is admitted to your unit for an elective hernia repair. He works as an office manager in a large manufacturing company. On admission you think you smell alcohol on his breath but when you ask about his drinking habits, he states he is a social drinker. At this time, Mr. Smith is mildly anxious. He has never been hospitalized before, and you attribute this anxiety to the fear of hospitalization and surgery. He has an uneventful evening and night. In the morning, you go to administer his preoperative diazepam (Valium®) as ordered by the anesthetist. At this time, he is moderately anxious, tremulous, agitated and perspiring profusely. His pulse is 110, his blood pressure is 140/100. What is happening to Mr. Smith? What can you, as his nurse, do?



The exact frequency of alcohol withdrawal experienced within a general hospital population is unknown, but recent statistics indicate that 30 percent of patients can be expected to be affected by some type of complications of alcohol abuse.<sup>1</sup> In any case, alcohol withdrawal is common and probably under-diagnosed. Many patients are treated for symptoms like those of Mr. Smith's without recognition that these symptoms are components of an alcohol withdrawal syndrome (AWS). The patient's major problem of alcohol abuse is often not recognized and appropriate rehabilitation steps are not considered.

An abstinence or alcohol withdrawal syndrome occurs when alcohol is eliminated or the amount normally consumed is decreased in individuals who consume large amounts over an extended period of time. The syndrome occurs because of the rebound excitability of the central nervous system effects as alcohol, a CNS depressant, is eliminated from the body. Occurrence of this abstinence syndrome indicates physical dependence on the drug.

AWS is classified into minor and major syndromes. The minor syndrome occurs a few hours after cessation of alcohol intake and lasts as long as 48 hours. The symptoms include tremor, sleeplessness and irritability. Grand mal seizures usually occur in the first sixty hours after cessation of drinking and typically are not the result of epilepsy. The major syndrome, *delirium tremens*, occurs 48-70 hours after cessation of alcohol intake. The symptoms include anxiety, agitation, disorientation, diaphoresis and hallucinosis. The traditional method of treating patients with AWS has been pharmacotherapy.

In a study of patients with AWS conducted at the Clinical Institute of the Addiction Research Foundation of Ontario, 67 percent of the patients studied suffering from moderate to severe alcohol withdrawal were treated successfully with supportive nursing care.<sup>2</sup> Other researchers have also produced similar results in treating patients in mild AWS.<sup>3</sup>

To give appropriate supportive care, nurses must recognize which patients are at risk, which symptoms comprise the total syndrome and which nursing measures alleviate the symptoms.

#### Assessment at admission

In addition to obtaining current medical and psycho-social histories upon admission of an individual to hospital, nurses must also assess alcohol consumption (See figure one). The statement that a patient is a social drinker should not be accepted at face value, rather the nurse should explore the amount, frequency and pattern of

**Figure one: Guidelines for Alcohol Consumption History and Risk Factors for AWS**

1. Alcohol consumption in last week?
2. Alcohol consumption in last 24 hours?
3. Average daily consumption?  
—At risk for AWS if daily consumption
  - 9 oz spirits or
  - 26 oz wine or
  - 21 oz fortified wine or
  - 6-12 oz bottles of beer
4. Continuous days of consumption at risk levels in number 3.  
—At risk for AWS if greater than 7 days.
5. Time since last drink.  
—At risk for AWS 0-60 hours after last drink if greater than risk levels in number 3 and greater than 7 days continuous drinking.
6. Any previous withdrawals, shakes, DT's? (if at risk from questions 3, 4, 5.)
7. Any previous seizures? (if at risk from questions 3, 4, 5)

alcohol use; Mr. Smith should have been asked the questions in figure one to determine his risk of developing AWS. However, the nurse must remember that alcohol dependent patients do not generally give reliable histories. Consequently, in addition to taking the patient history, the nurse must use his/her observational skills

and clinical judgment in assessing total risk. If possible, blood alcohol or breath alcohol concentrations should be determined. If the readings are above 1000 mg/l the patient would be considered at risk for AWS.<sup>4</sup>

#### Symptoms of AWS

In the study of AWS at the Clinical Institute, 39 patients were studied and their symptoms documented (See figure two). The symptoms of tremor, clouding of sensorium, agitation, quality of communication, thought disturbances, flushing of face and seizures were assessed by clinical observation. The symptoms of headache, shakiness inside, and patient feelings were assessed by patient report. All other symptoms were assessed using both patient report and clinical observation.

All symptoms, except seizures, were then rated on a continuum from none, or mild, through moderate to severe. Visual, tactile and auditory disturbances, for example, were rated as:

- not present
- mild sensitivity to sensory stimuli
- severe sensitivity to sensory stimuli, or
- severe hallucinations with gradations between these ratings.

Anxiety accounted for the major portion of the symptomatology, 63 percent. Tactile disturbances accounted for 11 percent; tremor, eight percent; visual disturbances, six percent; nausea and vomiting, four percent; and a clouding of sensorium, three percent. The remaining symptoms were not seen frequently, however the presence of

**Figure two: Alcohol Withdrawal Symptoms, Percent of Total Symptoms, and Method of Observation**

Symptom	Percent of Total Symptoms	Patient report	Clinical Observations
Anxiety	63%	X	X
Tactile Disturbances	11	X	X
Tremor	8		X
Visual Disturbances	6	X	X
Nausea and Vomiting	4	X	X
Clouding of Sensorium	3		X
Agitation			X
Temperature ( in AWS)			X
Pulse ( in AWS)			X
Respiratory Rate ( in AWS)			X
Blood Pressure ( in AWS)			X
Sweating			X
Auditory Disturbances		X	X
Hallucinations	5	X	X
Quality of Communication			X
Thought Disturbances			X
Headache		X	
Flushing of Face			X
Seizures			X
Are you shaky inside?		X	
How do you feel now?		X	





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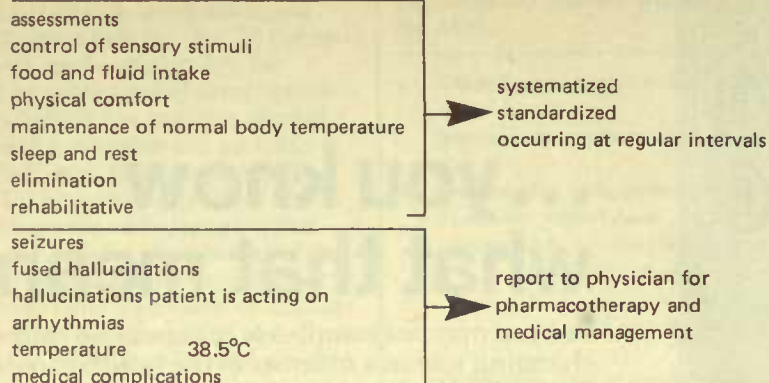
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**Figure three: Supportive Nursing Care**



these often indicate a greater probability of a need for pharmacotherapy.

*Your observations of Mr. Smith indicate that he has anxiety, tremor and agitation which are three of the most frequent symptoms of AWS. In addition, he has an elevated heart rate and blood pressure, and is perspiring, three of the less frequent symptoms. If his alcohol consumption history indicates he is at risk, then you can probably assess his condition as AWS.*

#### Supportive nursing care

The ideal drug for the treatment of AWS should not interact with alcohol, should not have any addictive properties, should be effective in the treatment of target symptoms and should prevent delirium tremens. Supportive nursing care is not a drug, but it does meet the first three criteria. In fact, current literature and research, indicate that supportive nursing care can help arrest the development of delirium tremens.

Assessment of the symptoms, outlined in figure two is part of the supportive care because the process provides a focus for interaction between patient and nurse at regular intervals. This nurse/patient communication reassures the patient about his present condition and serves as a reorientation to time, place and person.

Supportive care also includes control of sensory stimuli by providing a care area that is as private as possible. This involves a reduction in light and noise levels, and in the number of staff members in contact with the patient. Fluids such as milk and juice and soft foods are given. Tea and coffee intake is discouraged since the stimulant effects may increase the severity of the AWS symptoms. Methods of insuring physical comfort, sleep, rest, elimination and maintenance of normal body temperature are implemented. Very often during the supportive care, a patient will say, "Once I get through this, I'll never drink again." This is the ideal time to introduce treatment plans for his/her addictive disease.

Formulation of long term rehabilitation plans is highly effective when plans are made in this controlled and stable atmosphere. Of the 39 patients in the study, all were referred for long term rehabilitation; 21 have continued in treatment after discharge.

In the study of AWS patients at the Clinical Institute, assessments and supportive care were given every half hour up to every four hours. Other studies are being planned to evaluate the efficacy of supportive measures being applied hourly. The nurse in the general hospital should apply the care at regular intervals as the patient's condition dictates. The importance of this care is that it is systematized and standardized, and reassuring to the patient who can anticipate the care at predictable intervals.

The special problems of severe hallucinations, seizures, hyperthermia and arrhythmias usually require pharmacotherapy and must be reported to the physician for management (See figure three.)

*Assuming that Mr. Smith is in alcohol withdrawal, the nurse should advise the physician of the patient's condition and then decide with the physician whether to treat the patient with supportive care alone or with supportive care in conjunction with pharmacotherapy. The frequent assessments which follow allow the nurse to closely monitor the clinical course of the syndrome and to detect an improved, stable or deteriorating condition.*

Early and appropriate treatment for target symptoms benefits the patient. The nurse who can identify AWS identifies physical dependency on alcohol and can then initiate long term rehabilitation. This supportive care is only good nursing care but it is nursing's unique and independent contribution to Mr. Smith and other patients with AWS.

#### References

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\*Not verified



#### WANT TO READ MORE?

##### Books

- 1 Burkhalter, P. *Nursing the alcoholic and the drug abuser*. New York: McGraw-Hill; 1975.
- 2 Canada. Health and Welfare Canada. *Drug crisis treatment: a guide to medical management of acute drug toxicity*. Ottawa; 1976.
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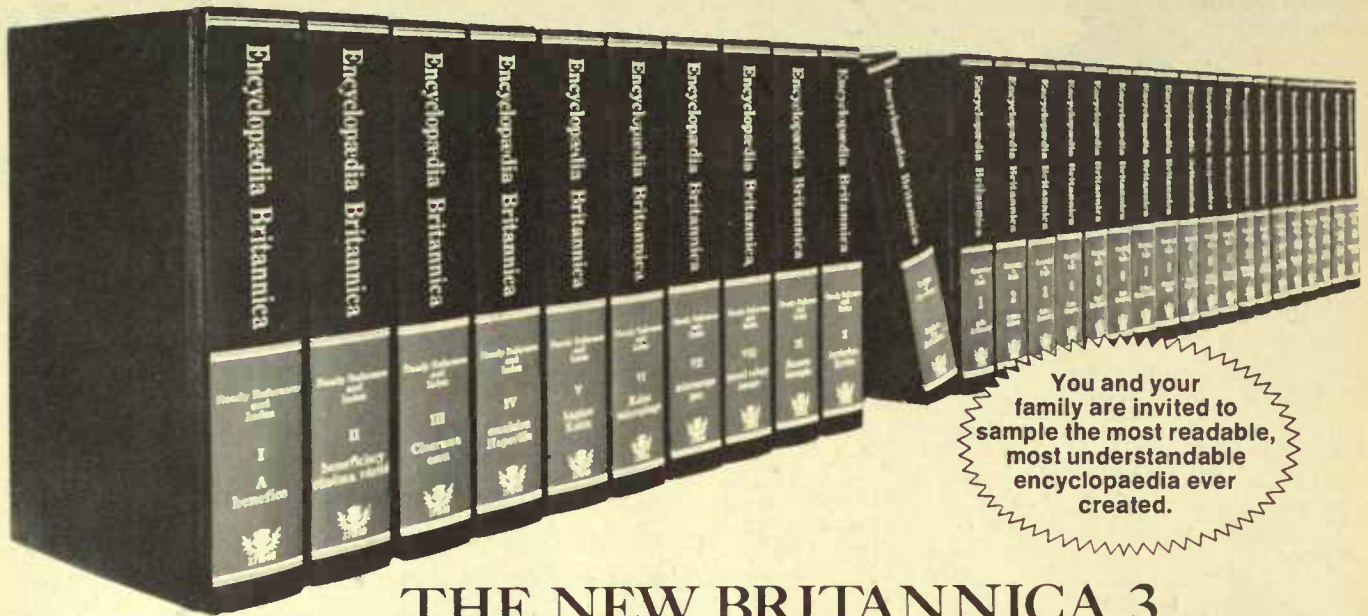
##### Papers, Pamphlets and Manuals

- 1 \*Addiction Research Foundation. *Can I take this if I'm pregnant?* Toronto: Pharmacy Service.
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- 5 \*Cork, M.R. *Alcoholism and the family*. Toronto: Addiction Research Foundation.
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- 7 Cox, Anne. *The management of intoxicated and disruptive patients: emergency department training manual*. Toronto: Addiction Research Foundation; 1979.
- 8 Dobbie, J. *Substance abuse among the elderly*. Toronto: Addiction Research Foundation; 1978.

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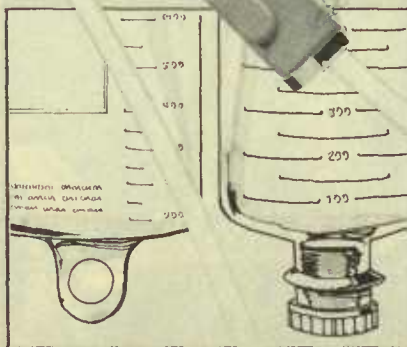
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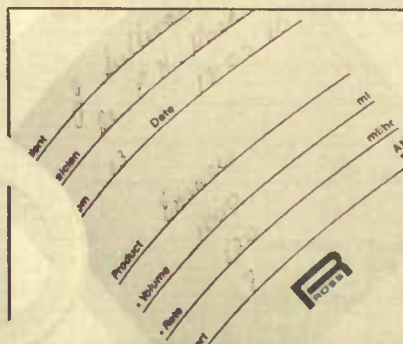
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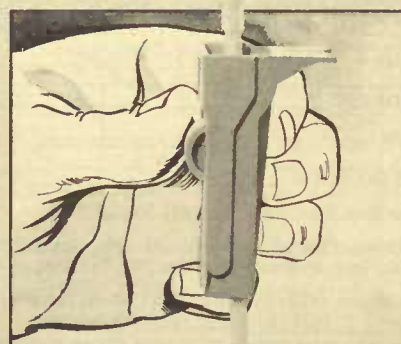
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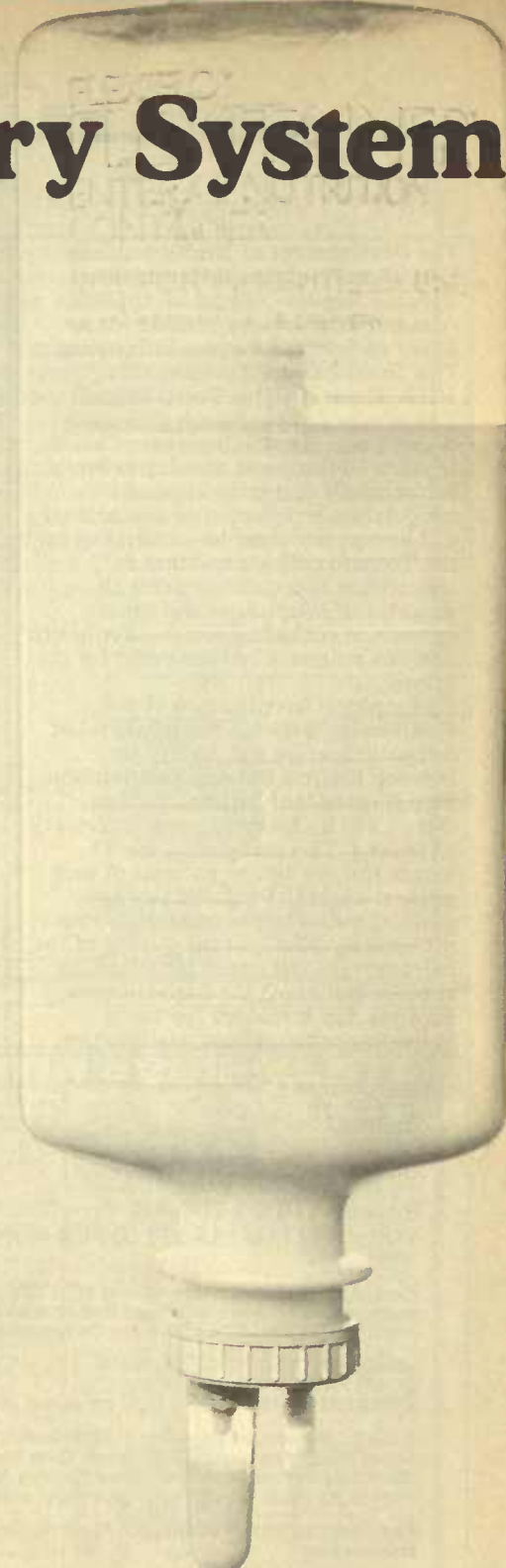
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# research

**The Development of Health Sciences Education Programs in Metropolitan Toronto Region Colleges of Applied Arts and Technology, 1967-1977; A Study of Selected Factors Influencing This Development.** Toronto, Ont., 1979. Thesis (D.Ed.), University of Toronto by *Lucille Peszat*. This study which traces the development of health sciences education at non-degree levels recommends that more regional cooperation and sharing of educational and human resources be undertaken by the Toronto colleges and that a consortium approach involving all educational institutions and other agencies in the region which offer health sciences programs be considered for the future.

**An Empirical Investigation of the Relationship between Nurse's Level of Self-actualization and Ability to Develop Positive Helping Relationships with Hospitalized Patients.** Ottawa, Ont., 1980 by *Marion Logan*, University of Ottawa. This study involving 71 nurses and one to five patients of each of these nurses, concluded that the nurse's level of self-actualization does not directly influence the quality of the helping relationship and questions the appropriateness of the Barrett-Lennard Relationship Inventory for use in evaluating nurse-patient relationships.

**The Relation of Constraint and Situational Theory to Diploma Nursing Program Leadership.** Detroit, Michigan, 1980. Thesis (PhD), Wayne State University by *Dolly Goldenberg*. Participating in the study were 35 heads of diploma nursing programs and 106 senior faculty members. The study substantiates the belief that nursing administrators view their leadership role as being primarily a supportive one; suggested a causal relationship between the phenomenon of follower-maturity and leader behavior; identified the need to further investigate environmental variables that impinge upon and affect leadership styles and identified that other personality or psychosociocultural variables have a probable effect on leader behavior.

**Commitment to the Nursing Profession: An Exploration of Factors Which May Explain its Variability.** Vancouver, B.C. Thesis (MScN). University of British Columbia by *Suzanne Flannery*. A five part questionnaire mailed to a stratified random sample of 400 nurses reveals that certain personal and work-related variables, i.e. professional orientation, marital status, basic education and work satisfaction, account for 23 percent of the variability to work commitment, leaving a large portion of the variability unexplained.

**Factors Influencing Dietary Adherence as Perceived by Patients on Long-term Peritoneal Dialysis.** Toronto, Ont., 1980. Thesis (MScN), University of Toronto by *Margaret Hume*. Descriptive study, sample of 25 men and women, 28 to 79 years of age having been dialysed for periods ranging from three months to four years. More positive than negative influences are reported, with health-related beliefs and values accounting for the majority of positive factors and situational factors relating to most of the negative factors.

**Child Rearing Concerns of First Time Mothers.** Kingston, Ontario, 1980 by *Faye Brooks* and *Lynn Kirkwood*. This feasibility study undertook to identify, on a longitudinal basis, the child rearing concerns of 56 first-time mothers; when they emerged and how they changed. The most common concerns involved infant care; it was identified prenatally and little change was noted throughout the course of the study. No effective tool was developed for eliciting mothering and family relationship concerns.

**Development and Validation of Information Needs Inventory (MI Patient).** Edmonton, Alberta, 1980 by *Marianne Lamb*, *Louise Payne*, and *Karran Thorpe*. This study was designed to develop and validate an instrument to measure the degree of importance of an item of knowledge for individuals who have experienced a myocardial infarction. A 75 item questionnaire (Information Needs Inventory) was developed and tested with 100 individuals. Some evidences of validity were established and recommendations are made for further development of the INI.

**H.E.L.P. (Health Evaluation and Lifestyle Promotion).** Calgary, Alta., 1979 by *Maryann Yeo*, University of Calgary. Descriptive study, sample of 250 individuals were given the Health Hazard Appraisal in industrial and physician's office settings with varying degrees of follow-up. The value of the Health Hazard Appraisal appears to be that of an awareness tool only, its usefulness as a measure of behavior change is questionable.

**The Effects of Two Types of Fetal Monitoring on Ability to Maintain Control During Labour.** Toronto, Ont., 1980. Thesis (MScN), University of Toronto by *Ellen Hodnett*. A two phase investigation of 100 postpartum women and 30 laboring primiparae revealed that the Labour Agency Scale is a useful tool for measuring experienced control in labour and that the type of fetal monitoring used influences experienced control.

*Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.*



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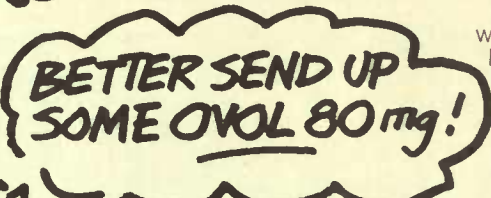
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- 9 —; Bill, P. *Fetal alcohol syndrome*. Toronto: Addiction Research Foundation; 1978.
- 10 Fraser, J. *The female alcoholic*. Rev. ed. Toronto: Addiction Research Foundation; 1976.
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- 12 Schmidt, Wolfgang; Popham, Robert. *Alcohol problems and their prevention: a public health perspective*. Toronto: Addiction Research Foundation; 1978.
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5 Mueller, J.F. et al. The role of the nurse in counselling the alcoholic. *J.Psychiatr.Nurs.* 12:26-32; 1974 Mar./Apr.

\*For further information and a price list for ARF publications, readers should contact:

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#### Did you know...

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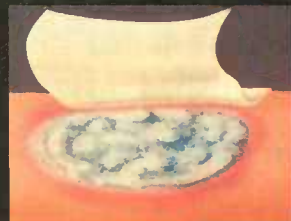
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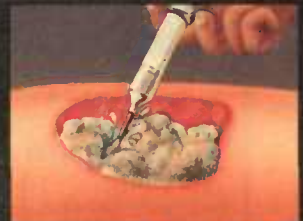
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#### References

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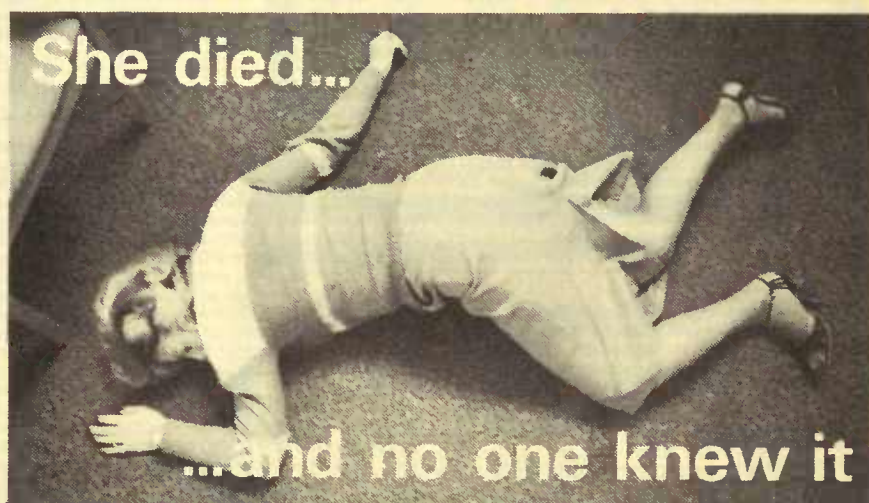
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## British Columbia

Experienced Nurses (eligible for B.C. Registration) required for full-time positions in our modern 300-bed Extended Care Hospital located just thirty minutes from downtown Vancouver. Salary and benefits according to RNABC Contract. Applicants may telephone 525-0911 to arrange for an interview, or write giving full particulars to: Personnel Director, Queen's Park Hospital, 315 McBride Blvd., New Westminster, British Columbia V3L 5E8.

General Duty Nurses required by an active 80-bed acute care and 40-bed extended care hospital located in the Cariboo region of B.C.'s central interior. Year round recreational activities in this fast growing community. Applicants eligible for B.C. registration preferred. Apply in writing to: The Director of Nursing, G.R. Baker Memorial Hospital, 543 Front Street, Quesnel, British Columbia V2J 2K7.

General Duty Nurses required immediately for a ten-bed acute and ambulatory care hospital located in Stewart, B.C. Stewart has a population of 2000 and is Canada's northernmost ice-free port with transportation, mining and construction as its primary industries. There are excellent school facilities. A few of the many sports offered are boating, fishing and, in the modern community pool, swimming. Stewart General Hospital is affiliated with the Prince Rupert Regional Hospital and nurses are encouraged to take part in the inservice education programmes at both hospitals. Salary rates are according to the RNABC contract and for a general duty RN the ranges are: May 1, 1980—\$1624-\$1889 plus \$26.87 northern allowance. Jan. 1, 1981—\$1700-\$1965 plus \$28.12 northern allowance. Fringe benefits include: 20 days paid annual vacation; 5 days marriage leave; annual educational leave, in addition to the other usual health care insurance and monetary benefits. We are eager to help you relocate. For further information please call COLLECT: (604) 624-2171, ask for Mrs. L. Bremner, Director of Nursing.

O.R. Head Nurse required for an active 103-bed acute care hospital. Must be eligible for B.C. Registration. Post graduate training & experience necessary. R.N.A.B.C. Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

General Duty Nurses required for an active, 103-bed hospital. Positions available for experienced R.N.'s and recent Graduates in a variety of areas. RNABC Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

## New Brunswick

Registered Nurses—The Moncton Hospital a 539-bed fully accredited General Hospital is accepting applications for full time positions from General Staff Nurses. Rates and benefits in accordance with the Provincial Agreement. Replies and inquiries should be addressed to: Personnel Office, The Moncton Hospital, 135 MacBeath Avenue, Moncton, New Brunswick E1C 6Z8.

## Northwest Territories

The Stanton Yellowknife Hospital, a 72-bed accredited acute care facility requires registered nurses to work in medical, surgical, paediatric, obstetrical or operating room areas. For further details concerning salary and benefits contact: Lynette McLeod, Personnel Officer, Box 10, Yellowknife, N.W.T. X1A 2N1. (403) 873-3444 (Collect).

## Ontario

R.N. or R.N.A., 5'6" or over and strong without dependents. Non-smoker for 180 lb. handicapped retired executive with stroke. Able to transfer patient to wheelchair. Live in 1/2 year in Toronto 1/2 year in Miami. 4 day work week most of year. Wages \$275.00 to \$350.00 weekly NET plus \$100.00 weekly bonus on most weeks in Miami. Free room and board. Write: M.D.C., 3532 Eglinton Avenue West, Toronto, Ontario M6M 1V6.

## Quebec

Registered Nurses: Full-time and part-time positions for modern 50 bed Nursing Home located in small community setting in Western Quebec 50 miles from Ottawa. Excellent salary and benefits. Applicants should write giving full particulars to: Director of Nursing, Pontiac Reception Centre, Shawville 2001, Quebec J0X 2Y0.

## Saskatchewan

Registered Nurses and Registered Psychiatric Nurses (eligible for Saskatchewan registration) required for 340 fully accredited extended care facility. For further information contact: Personnel Department, Souris Valley Extended Care Hospital, Box 2001, Weyburn, Saskatchewan, S4H 2L7.

## United States

RN/Staff & Management Positions—Kaiser-Permanente, the country's largest Health Maintenance Organization, currently has excellent opportunities available in our 583-bed Los Angeles Medical Center. Located 7 miles from downtown Los Angeles, close to many of California's finest Universities, this teaching hospital offers RN's a unique chance to further their careers in such areas as: OR, Med/Surg, Maternal Child Health & Critical Care. Management positions are also available. Kaiser offers an attractive array of fringe benefits including relocation assistance, full medical, dental & health coverage, continuing education advanced training available in the Nurse Practitioner & CRNA Programs, individualized orientation, tuition reimbursement, and no rotating shifts. New graduates are always welcome and encouraged to inquire. For more information, please write or call collect: Ann Marcus, RN, Kaiser Hospital/Sunset, 4867 Sunset Blvd., L.A., California 90027. (213) 667-8374.

California—Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, Ext. 1680.

Total patient care with all licensed personnel is our goal! Staff RNs currently interviewing for part-time and full-time positions. Full service, except psych, progressive 156-bed accredited acute general hospital. Located within 60 minutes from L.A., the ocean, mtns., and the desert. Orientation and staff development programs. CEUs provider number. Parkview Community Hospital, 3865 Jackson Street, Riverside, California 92503. Write or call collect 714-688-2211 Extension 217. Betty Van Aernam, Director of Nursing.

## United States

RN'S—Our Florida hospitals need you! Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. No Fees! Call or write: Medical Recruiters of America, 3421 West Cypress St., Tampa, Florida 33607 (813) 872-0202.

Registered Nurses Virginia, USA—The Medical College of VA Hospitals is a 1058 bed, full service, referral, and research University hospital comprised of 50 specialty units within the nursing department; including Oncology, Medicine, Surgery, OB/GYN, Pediatrics, Critical Care, OR/RR and Outpatients. You may specialize in nursing and continue education through in-service workshops or pursue B.S.N. or M.S.N. (100 per cent tuition reimbursement for 12 credits/year) in our school of nursing. We offer competitive salaries and fringe benefits. Personal interviews will be arranged. To learn more call collect 804-786-0918 or write to Wanda Barth, MCV Hospitals, Box 7, Richmond, VA 23298. An Equal Opportunity Employer.

## Miscellaneous

Adventure Holidays: Camping Safaris, Overland Expeditions and Fun Experiences. We offer trips from one week to 3 months in: Canada, USA, Europe, Africa, Asia, South and Central America, Australia, New Zealand and the Caribbean. For FREE catalogue, contact your travel agent, or apply to: Goway Travel, 53 Yonge St., Suite 101, Toronto, Ontario M5E 1J3. Phone: 416-863-0799. Telex: 06-219621.

Looking For A Temporary Change? Do you want to keep your job but feel the need for some renewing experience? International registry for nurses interested in a temporary job exchange under organization. Write: Nursing Job Exchange, Box 1502, Kingston, Ontario K7L 5C7.

## NEW ADVERTISING RATES

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### Try International Nursing - In Saudia Arabia

If you are looking for a change, a chance to travel, some hard work and adventurous living, then you might consider international nursing. You will have not only the opportunity to give — to share your nursing expertise — but the opportunity to receive as well — to learn by living in a completely different culture. Truly, a chance for personal and professional growth.

Available positions include both administrative and staff level nursing. Requirements depend on the position — at staff level a minimum 2-3 years current experience in an acute care hospital or clinic setting. Current R.N. license in one of the Provinces. Single status contracts are offered for 18 or 24 month periods.

Attractive salaries with excellent benefits including air transportation, furnished lodging, generous vacation, bonus pay and bonus leave.

Interested in this once in a lifetime opportunity? For more details, please send professional resume to:

Kathleen Langan  
Hospital Corporation International, Ltd.  
Two Robert Speck Parkway, Ste. 750  
Mississauga, Ontario L4Z 1H8

An Equal Opportunity Employer

## Pediatric & Orthopedic Nurses

Jazz up your career at  
JoEllen Smith/  
F. Edward Hebert Hospitals  
in New Orleans

Most hospitals sing the same song . . . good salary, good benefits, good facilities. We go beyond that. We encourage each nurse to grow as an individual.

Leadership training to help you move up. Unlimited opportunities to learn as we open new services and pioneer new techniques. Plus a professional atmosphere where your special talents are appreciated.



Call collect (512/824-7478) or write:  
J. Philip Knight-Sheen  
1635 N.E. Loop 410  
Suite 501  
San Antonio, Texas 78209

## Clinical Nurse Specialist Haematology/Oncology

**DUTIES:** The successful applicant will be required to work with other health care professionals in the in-patient and out-patient areas served by the Haematology Oncology Department. Contact will be primarily with children who have malignant illnesses, and their families. Attention is concentrated on families at crisis time, such as diagnosis, relapse, terminal phase, and death of the child. Staff education and research activities are additional responsibilities of this position.

### QUALIFICATIONS:

- Current registration in Ontario or eligibility for registration is essential.
- Masters Degree in Paediatric Nursing essential
- Recent related nursing experience preferred
- Demonstrated ability to work harmoniously with patients, families and staff.

Please apply to:



Dorothy Franchi  
Personnel Co-ordinator  
The Hospital for Sick Children  
555 University Ave.  
Toronto, Ontario M5G 1X8  
(416) 597-1500 Ext. 1528, 1677

## The Hospital for Sick Children



## PROVINCE OF NOVA SCOTIA CAREER OPPORTUNITIES

### Supervisor, Community Health Nursing

The Nova Scotia Department of Health invites applications for the position of Supervisor, Community Health Nursing for the Cobequid Health Unit based in Truro, Nova Scotia. This position offers the opportunity to contribute to the provincial community health services system, as well as the responsibility of managing the nursing program of this Health Unit.

The incumbent of this position reports to the Health Unit Director and is responsible for a number of delegated managerial functions. The supervisor also provides the professional supervision of approximately 22 community health nursing personnel in consultation with the Director of Community Health Nursing.

The successful applicant will have current registration as an R.N. in Nova Scotia, along with a Master's Degree in community nursing and nursing administration or equivalent. A minimum of five consecutive years nursing is desirable.

#### Salary Range:

\$19,713.72 – 22,020.96.

Full Civil Service Benefits.

Competition is open to both men and women.

Please quote Competition Number 80-337.

Closing Date: November 14, 1980.

Application forms may be obtained and should be returned to the Nova Scotia Civil Service Commission, P.O. Box 943, Halifax, Nova Scotia, B3J 2V9, and from the Provincial Building, Sydney, Nova Scotia, B1P 5L1.

### Head Nurse - Psychiatry

A 289 bed accredited hospital, located in Chilliwack, B. C., requires a Head Nurse for its Psychiatric Unit.

The successful applicant will be responsible for the organizing, teaching and supervision of the nursing staff. A post graduate course in Psychiatry, demonstrated leadership abilities, and effective management skills are essential with a B.Sc.N. preferred.

Must be eligible for current R.N.A.B.C. registration and have three years psychiatric experience - one of which must have been at the supervisory level.

Salary and benefits as per R.N.A.B.C. Collective Agreement.

Please submit resume, in confidence to:

Personnel Director  
Chilliwack General Hospital  
45550 Hodgins Avenue  
Chilliwack, British Columbia  
V2P 1P7

### Toronto Western Hospital

#### "The Home of Friendly Care and Protection"

This 700 bed University Teaching Hospital has employment opportunities for registered nurses, or nurses eligible for Ontario Registration in such areas as:

- Medical/Surgical Units
- I.C.U./C.C.U.
- Operating Rooms

Planned orientation and on-going education programme in effect.

Apply to:

Miss H. Jones  
Staffing Co-ordinator  
Department of Nursing  
Toronto Western Hospital  
399 Bathurst Street  
Toronto, Ontario  
M5T 2S8

## Interested In Paediatric Nursing ? Toronto, Canada

The Hospital For Sick Children invites applications for all units from experienced nurses interested in working in a paediatric tertiary care setting.

We are a fully accredited 700 bed paediatric teaching hospital affiliated with the University of Toronto located in the thriving environment of downtown TORONTO. A thorough orientation and a variety of continuing education programs is provided. The majority of units operate on a 12 hour shift basis, which normally allows every other weekend off. A comprehensive employee benefit package, including a Dental Plan is offered.

Our philosophy is Family Centred Care.

#### Qualifications:

- Current registration with the Ontario College of Nurses or eligibility for registration.
- Recent related experience in an active treatment setting preferred.
- Paediatric experience would be considered a definite asset.

Applicants are invited to contact:



Dorothy Franchi,  
Personnel Co-ordinator,  
The Hospital for Sick Children,  
555 University Avenue,  
Toronto, Ontario, Canada M5G 1X8,  
(416) 597-1500 ext. 1675.

## The Hospital for Sick Children



# Royal Alexandra Hospital

This 938 bed active treatment hospital invites applications from nurses across Canada.

We offer experience in all areas of patient care including intensive care, neonatal intensive care and obstetrical perinatology. The extended work day and compressed work week is currently in effect in the Intensive Care areas and Emergency.

Applicants must be eligible for registration with the Alberta Association of Registered Nurses.

Please direct inquiries to:

Mrs. D. Kivell  
Personnel Officer  
Nursing Recruitment  
Royal Alexandra Hospital  
Room 1108  
10204 Kingsway  
Edmonton, Alberta  
T5H 3V9



Assistant Director Clinical Nursing  
(General Surgery, Thoracic Surgery,  
and Gastroenterology) **NEW POSITION**

Assistant Director Clinical Nursing  
(Internal Medicine) **NEW POSITION**

Assistant Director Clinical Nursing  
(Orthopedics and Outpatient Surgery)

#### Hospital:

The Plains Health Centre, a division of the South Saskatchewan Hospital Centre, is a 300 bed fully accredited teaching hospital.

#### Position:

In a decentralized nursing structure that separates clinical and administrative functions, the incumbents will be responsible for the quality of nursing care developed and provided to 36 patients.

#### Qualifications:

A baccalaureate or post-basic degree. Evidence of progress towards attainment of a degree will be considered. Teaching experience an asset. Applicants with three or more years experience in the clinical areas specified will be given preference.

Full range of fringe benefits, salary currently under review.

Reply to:

Personnel Department  
South Saskatchewan Hospital Centre  
Plains Health Centre Division  
4500 Wascana Parkway  
Regina, Saskatchewan  
S4S 5W9

## Registered Nurses

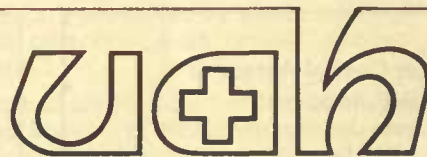
1200 bed hospital adjacent to University of Alberta campus offers employment in medicine, surgery, pediatrics, orthopaedics, obstetrics, psychiatry, rehabilitation and extended care including.

- Intensive care
- Coronary observation unit
- Cardiovascular surgery
- Burns and plastics
- Neonatal intensive care
- Renal dialysis
- Neuro-surgery

Planned Orientation and In-Service Education Programs. Post Graduate Clinical Courses in Cardiovascular-Intensive Care Nursing and Operating Room Nursing.

Apply to.

Recruitment Officer - Nursing  
University of Alberta Hospital  
8440-112th Street  
Edmonton, Alberta  
T6G 2B7



University of  
Alberta Hospital

Edmonton, Alberta





# Choose a Nursing Career in Canada's Ocean Playground



The Victoria General Hospital, Halifax, Nova Scotia is the Maritime's largest teaching hospital. Close association with Dalhousie University and our own extensive continuing education program provide excellent opportunities for learning and career development.

The Victoria General Hospital offers a variety of nursing specialties for experienced people looking for a professional environment and challenge. Victoria General Nurses have full civil service benefits.

- **GENERAL DUTY NURSES** work in our 28 general nursing units, each of which have specific sub-specialties in Medicine and Surgery.
- **INTENSIVE CARE NURSES** are part of five specialized units such as Coronary, Cardiovascular, Medical, Surgical and Neurosurgery.
- **SPECIALTY AREA NURSES** work in the Burn Unit, Renal Unit, Emergency, Operating Room, Recovery Room or Out-Patients.
- **NURSING ADMINISTRATION.** We encourage promotion through an on-going program of leadership development.

Please quote Competition Number: 80-310.

For details on nursing opportunities contact:

Mrs. Betty Elliot, R.N.

Personnel Department, Victoria General Hospital

5788 University Avenue

Halifax, Nova Scotia B3H 1V8

Telephone: 1 (902) 428-3484



**MIDWIFERY TUTOR — NIGERIA**  
**NURSING INSTRUCTORS — COLOMBIA & PAPUA NEW GUINEA**  
**PROFESSOR OF NURSING — PERU**  
**PUBLIC HEALTH NURSES — WEST AFRICA & PAPUA NEW GUINEA**

CUSO, Canada's largest non-government international development agency, is seeking qualified and experienced nurses for the above positions.

**Qualifications:** Positions require appropriate degree (diploma for midwifery position) plus relevant experience.

**Contract:** Two years.

**Salary:** At local rates with fringe benefits.

For more information, write:

CUSO Health D1 Program  
151 Slater Street  
Ottawa, Ontario  
K1P 5H5

## The Izaak Walton Killam Hospital for Children

### Assistant Head Nurse Neo-Natal

The I.W.K. Hospital for Children requires an Assistant Head Nurse for our Neo-Natal Unit, which is a 32-bed referral centre providing intensive, intermediate and convalescent care.

Applicants must be a graduate of an accredited School of Nursing and eligible for registration in Nova Scotia. Degree or Diploma in Nursing Service Administration is preferred. Must have a good knowledge of Neo-Natal nursing principles and techniques.

Inquiries and applications should be directed to:

Karen Lyle, Personnel Officer  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
B3J 3G9

## Cancer Control Agency of British Columbia

### Oncology Nursing

The Cancer Control Agency of British Columbia, a provincial cancer diagnosis and treatment center located in Vancouver, has general and senior administrative openings for oncology nurses beginning immediately and running through November 30, 1980. The positions include responsibilities in both inpatient and ambulatory care settings.

Applicants should send a resume to:

Sue Rothwell  
Director of Nursing  
Cancer Control Agency of B.C.  
2656 Heather Street  
Vancouver, British Columbia  
V5Z 3J3

Phone No: (604) 873-4221,  
Local 37



## Attention Registered Nurses

The Saint John Regional Hospital has Full Time, Part Time, and Casual positions available for Registered Nurses, to participate in the planning and giving of total nursing care in Medical, Surgical, and Geriatric Units.

**Hours of Work:**  
37-1/2 hour work week (Twelve or Eight hour shifts).

**Qualifications:**  
Graduate of an approved School of Nursing.  
Must be eligible for registration in the province of New Brunswick.

**Salary:**  
Contract presently under negotiations.

Excellent fringe benefits include three weeks vacation after one year's service, paid sick leave, annual increments, group life insurance, and hospital pension plan.

Interested persons please apply in writing to:

Employment Manager  
Saint John Regional Hospital  
P. O. Box 2100  
Saint John, New Brunswick  
E2L 4L2



## Nursing Education Co-Ordinator

required by  
Fort McMurray Regional Hospital  
**Effective:** Immediately

**Responsibilities:**  
Responsible for nursing orientation, staff development and monitoring of primary nursing in a new active treatment hospital (150 beds expanding to 300 beds).

Responsible to the Vice-President of Patient Services.

**Qualifications:**  
B.ScN. with teaching experience or equivalency.

Applications with curriculum vitae to be submitted to:

Personnel Department  
Fort McMurray Regional Hospital  
No. 7 - Hospital Street  
Fort McMurray, Alberta  
T9H 1P2  
(403) 791-6031



## PROVINCE OF NOVA SCOTIA CAREER OPPORTUNITIES

### Registered Nurses

An Opportunity To Use Your Knowledge and Skills

#### The Hospital:

The Nova Scotia Hospital is a 400 bed, fully accredited, active treatment facility for the care and treatment of psychiatric patients. It is a teaching hospital and is affiliated with Dalhousie University. Being the major psychiatric referral hospital for the Province of Nova Scotia, it offers a full range of services for children, adolescents, geriatrics, mental retardation, and adults, as well as forensic services and a Community Clinic. A Day Hospital will be opening early in the Fall.

#### Its Location:

The Hospital is located in the City of Dartmouth on the shores of Halifax Harbour, with direct access to cultural and recreational facilities. It is just minutes from the City of Halifax, Nova Scotia's Provincial Capital.

#### The Job:

Using a team approach, we focus on short term, active treatment for the majority of patients. We also have ongoing and innovative programs for the small number of long term patients. Due to an increase in our staff quota, we require Registered Nurses for all inpatient services.

#### Educational Opportunities:

The Nova Scotia Hospital offers:

- a two week orientation program;
- clinical supervision and instruction for all staff;
- an inservice program in psychiatry and psychiatric nursing for new R.N.'s;
- seminars, workshops and ongoing continuing education programs for all staff.

A six month post graduate course in psychiatric nursing is available at the Nova Scotia Hospital School of Nursing.

Please quote Competition Number 80-335.

Full Civil Service Benefits.

Competition is open to both men and women.

For further information and/or application forms please contact:

Ms. Geraldine Webber  
Director of Nursing  
Drawer 1004  
Dartmouth, Nova Scotia  
B2Y 3Z9

Telephone: (902) 469-7500



## This nurse —a very special person to a very special people

An important responsibility of the federal government is to provide health care for the more than 295,000 registered Indians located throughout Canada.

Here a nurse may have to make decisions about the probable cause of illness and the appropriate care until help arrives or the patient can be moved to hospital. **Self-reliance** and **judgment** are essential, but you are never alone carrying total responsibility because you are supported by senior nursing and medical personnel, both "on call" and on "routine visits".

As a member of our Medical Services team, you are an **important member of the community you serve**. There are opportunities for promotion and travel, and to further your education at university. As well as your salary, there are special allowances and benefits such as travel expenses, overtime compensation, isolation post allowances, superannuation and holidays, plus the opportunity to see distant parts of Canada.

To the Indian people you serve, you are a **very special person**.

For further information, mail coupon below.

Nursing Advisor  
Human Resource Planning  
Medical Services Branch  
Department of National Health and Welfare  
Ottawa, Ontario K1A 0L3

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

PROV \_\_\_\_\_ CODE \_\_\_\_\_



Health and Welfare  
Canada

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Canada

# Canada





## Clinical Specialist of Medicine/Psychiatry

required by

Fort McMurray Regional Hospital

Effective: Immediately

### Responsibilities:

1. Responsible for the management of a Medical/Psychiatric unit.
2. Utilizing Primary Nursing in a new active treatment hospital (150 beds expanding to 300 beds).
3. Responsible to the Vice-President of Patient Services.

### Qualifications:

B.Sc.N. with management experience or equivalency.

Applications with curriculum vitae to be submitted to:

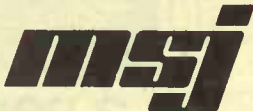
Personnel Department  
Fort McMurray Regional Hospital  
No. 7 - Hospital Street  
Fort McMurray, Alberta  
T9H 1P2  
(403) 791-6031

## Registered Nurses

300 bed Accredited general hospital in Vancouver requires full-time, part-time and casual R.N.s for general duty and ICU nursing. Candidates should be eligible for registration in B.C. Recent nursing experience preferred. ICU candidates must have previous ICU experience.

Please apply to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C.  
V5T 3N4



## Fanshawe College London, Ontario

Invites applications for the following position:

### Teaching Master Health Sciences (Continuing Education)

**Duties:** To teach the Post Diploma Registered Nurse Neurological Nursing Programme. This is a sessional appointment for the period January 5, 1981 to May 29, 1981.

**Qualifications:** B.Sc.N or equivalent University degree with a post diploma programme in Neurological Nursing and related clinical and teaching experience.

Please submit applications to:  
Personnel Services, Fanshawe College,  
P.O. Box 4005, London, Ontario  
N5W 5H1.

Closing date for applications –  
December 1, 1980.

The College encourages applications  
from both men and women.

## The Izaak Walton Killam Hospital For Children

### Staff Nurses

The I.W.K. Hospital for Children has vacancies for Staff Nurses on our Intensive Care Unit and Neo-Natal Unit. Must be a graduate from an accredited School of Nursing and be eligible for registration in Nova Scotia. Previous pediatric experience would be an asset.

Inquiries and applications should be directed to:

Karen Lyle  
Personnel Officer  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
B3J 3G9

## Sacred Heart Hospital McLennan, Alberta

### General Duty Nurses Required

For sixty-three (63) bed active treatment hospital. Must be registered or eligible for registration with the A.A.R.N. Salaries and benefits per U.N.A. and A.H.A. contracts.

Address all enquiries and applications to:

Director of Nursing  
Sacred Heart Hospital  
P. O. Box 390  
McLennan, Alberta  
T0H 2L0

(403) 324-3730

## Royal Jubilee Hospital Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with  
R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

Ryerson Polytechnical Institute  
Nursing Department  
Toronto, Ontario

### Applications are invited for Faculty Positions in the Following Areas of the Baccalaureate Program

Psychiatric nursing and Community  
Health Nursing

### Qualifications:

Preference will be given to applicants with Master's preparation in the areas noted and to applicants with current clinical and teaching experience.

Salary and benefits determined by  
relevant collective agreement.

For information contact:

Gail Donner  
Chairperson  
Nursing Department  
Ryerson Polytechnical Institute  
50 Gould Street  
Toronto, Ontario M5B 1E8

## Public Health Nurse

Applications are invited for the position of Public Health Nurse for the Stoney Health Centre, Morley, Alberta.

Program Administration responsibility as well as supervision of staff, also able to assist in operation of clinic when required.

### Qualifications:

Public Health Diploma or Bachelor of Nursing.  
Current A.A.R.N. Registration or qualification thereto.  
Five years experience in General Nursing.  
Ability to establish and maintain good relationship and deal effectively with patients, staff and public.  
Ability to use independent judgement, initiative and discretion.  
Must possess a high Degree of Maturity.  
Experience working with Native peoples an asset.

Apply and submit resume to:

The Administrator  
Stoney Health Centre  
P. O. Box 8  
Morley, Alberta  
T0L 1N0

## Registered Nurses

required

Applications are invited from Registered Nurses interested in full-time employment in a fully-accredited, 65-bed personal care home in Notre Dame de Lourdes, Manitoba, 90 miles Southwest of Winnipeg.

Excellent personnel benefits as well as rotations of Days/Evenings with every other weekend off are offered. Salary range is in accordance with current contract.

Qualified individuals are directed to forward their applications to the attention of:

Jacqueline Thérout  
Director of Nursing  
Foyer Notre Dame Incorporated  
Notre Dame de Lourdes, Manitoba  
R0G 1M0

Telephone: (204) 248-2092



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# input

## An easier death

I was thoroughly annoyed by the opening sentence of Vera McIver's article on dying in hospital (A time to be born, a time to die, September, 1980) which read, "for years, our institutions, the people who administer them, the doctors and nurses who work in them, have conspired to rob the dying patients of their individuality." I think that like most nurses I am well-intentioned and wish to give good care to my patients. I do not always succeed but there are reasons for that which do not come from malevolent intent.

First, what does the work situation contribute? McIver praises the hospice setting. I quite agree—but it is totally geared for the dying rather than the "curing" patient. The pace is slower and the staff as well as the patients are nourished and supported. Nurses have more time to give nursing care, the ethic is one of encouraging family ties and personal relationships, and there is peer support for the nurse whose feelings are temporarily a little off-balance because of her response to her patients. A pressured, worried mother gives short shrift to the emotional idiosyncrasies of her children—she attends to their obvious needs and that is all she can manage. A nurse is no different—if overwhelmed by the physical needs and anxieties of too many patients she will become curt.

Second, nurses are still given little expert teaching concerning listening skills. They come to difficult, emotionally-loaded situations with less training about how to handle them than they have had in giving enemas. There are conferences and classes for students about patients' emotional needs but not much high-level supervision of their emotional interactions with patients by nurses very skilled themselves in that aspect of care. Scolding nurses for not giving empathic nursing care is unempathic in itself; teaching them how to do so—as I suspect most want to—is more profitable.

McIver ignores the variable of the patient. Some people are easier to support than others; they have the

knack of drawing our interest rather than alienating it when they are upset. These people will be cared for better no matter what the setting or the nurse's training. This doesn't mean that the less sympathetic individual deserves less care, but the path to his death will be harder for him and his caretakers.

I have no wish to absolve nurses of responsibility for their part in not demanding better conditions for their dying patients or for going along with abuses rather than fighting for change. But although I have met a very very few nurses who seem to enjoy their power over patients, most, if they have blunted their sensibilities, have done so because of the stress they feel in the situation and herein lies the problem. To put this letter into one sentence—I object to once more being a villain.

—Susanna Jack, RN, M.Ed.,  
Montréal, Québec.

## Feedback

Your interesting magazine is occasionally read by members of my family in addition to my wife (RN—graduate of the Quo Vadis School of Nursing, Toronto). The article in this month's issue, "A time to be born, a time to die", by Vera McIver proved helpful to my daughter in a school project.

In the same issue, I felt the article "Whatever happened to the spiritual dimension", by Donelda Ellis was excellent. Congratulations on a thoughtful, well-written and timely article.

—T. Stevens, P.Eng., Winnipeg,  
Manitoba.

Many, many thanks for Donelda Ellis' September 1980 article, "Whatever happened to the spiritual dimension?" As a Christian nurse, I have been wondering if you would have just such an article. Thank you and may there be more.

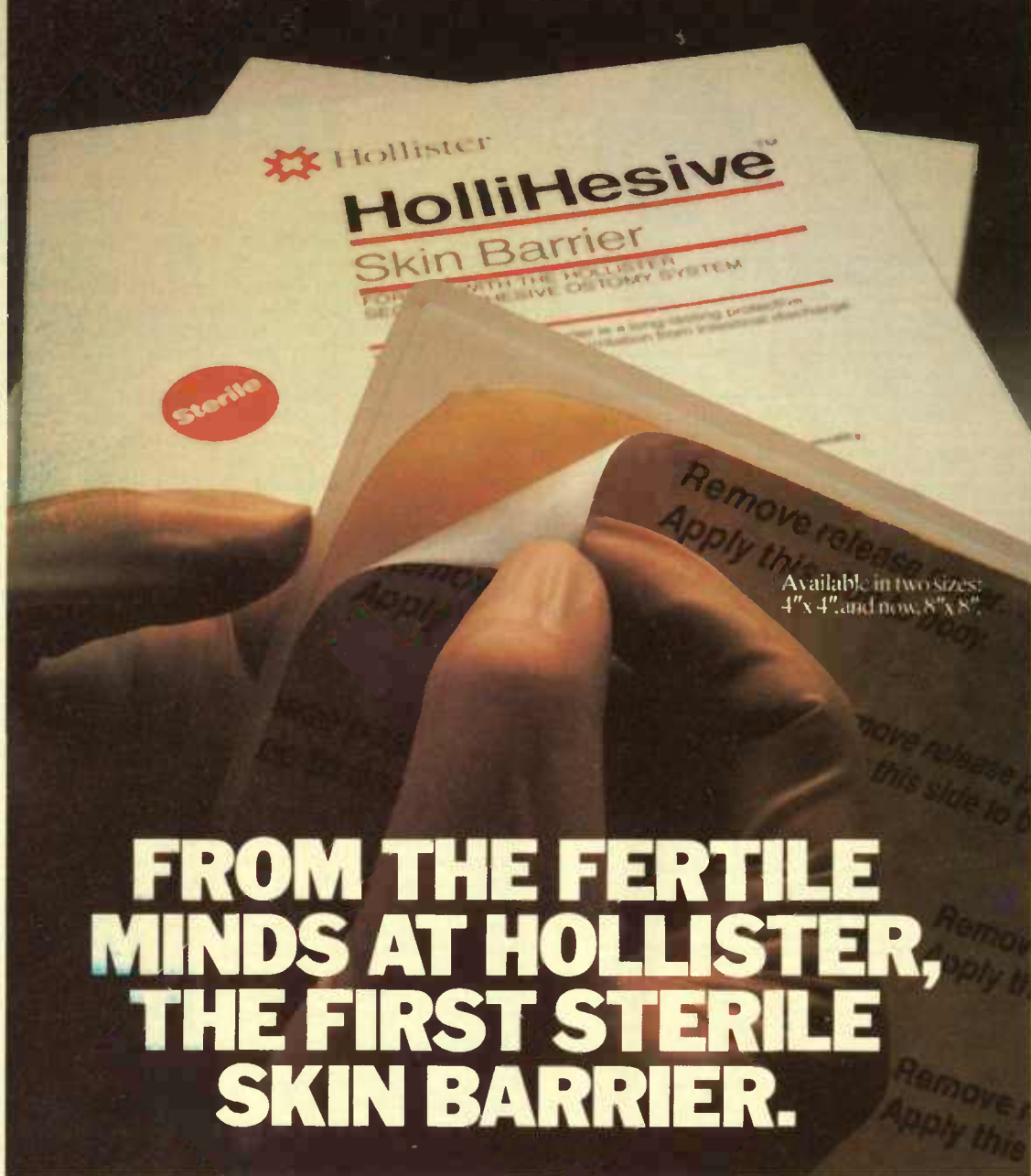
—Barbara Cope, RN, Otterville, Ontario.

## Did you know...

Copies of the 1978 National Conference on Nursing Research, "Methodology in Nursing Care Research, Issues, Innovation, Problems", are available from the College of Nursing, University of Saskatchewan, Saskatoon, Sask., S7N 0W0. Cost: \$9.00.

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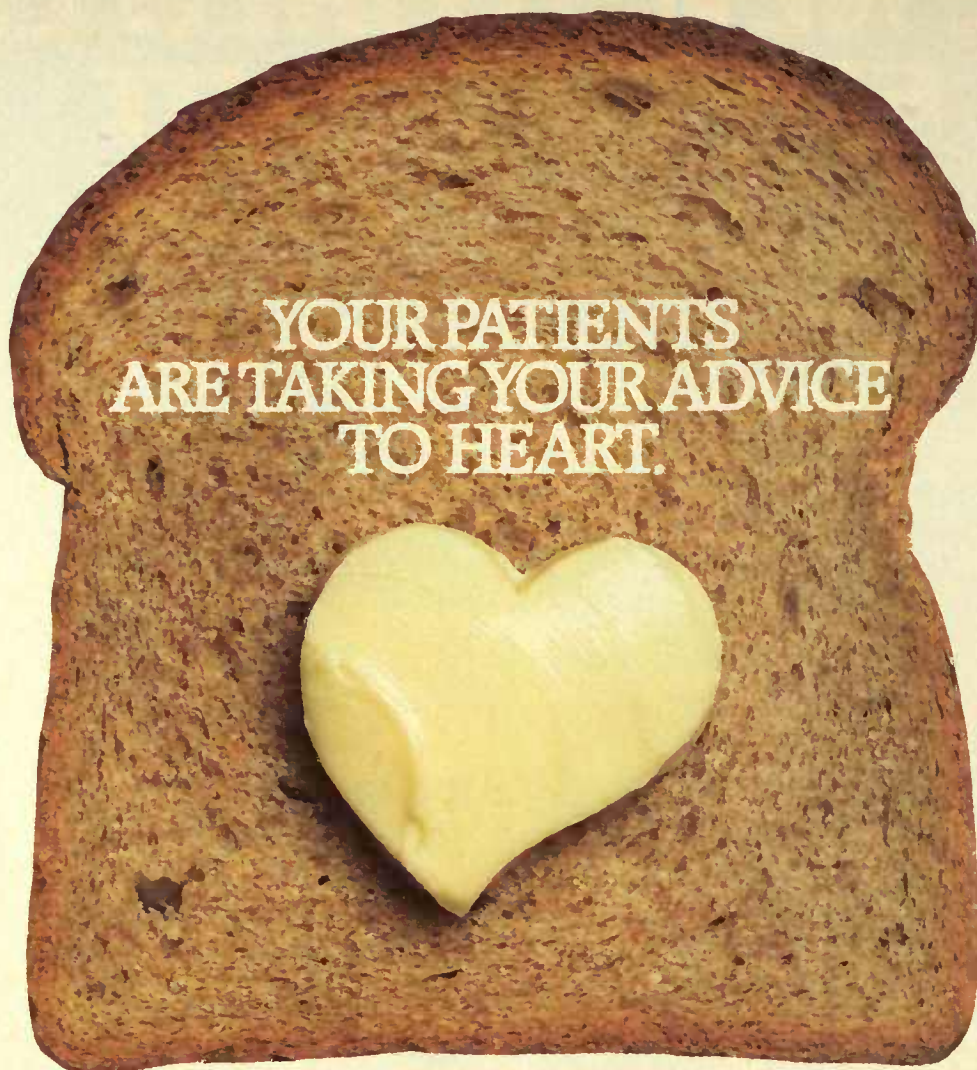
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# The Canadian Nurse

DECEMBER 1980

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## Occupational health nurses urged to take aggressive stand

Blow your own horn, and maybe make it an airhorn! That's the message 480 OHN's got at the Ontario Occupational Health Nurses' conference in Ottawa last October. The theme of the meeting was 'Excellence in the Eighties', and the nurses learned from a variety of speakers how they could both improve and evaluate their programs in the workplace, and how they could sell management on the job they're doing.

The keynote address was given by RNAO president Jocelyn Hezekiah, who pointed out that excellence in occupational health nursing was difficult to assess because "preventing illness is harder to measure than curing illness." She mentioned that with the acceleration of conflict and stress in society today, the OHN's work was becoming more difficult but that through management of stress (both the worker's and the nurse's), continuing education, and working with one's professional association, the nurse working in industry could achieve excellence by doing the best she can in any situation.

Josephine Flaherty, Principal Nursing Officer, Health and Welfare Canada, said that nurses may have to put aside the traditional methods of health care and decide that whatever works is what they should be using. She said that it's difficult to get people interested in health promotion programs, even the ones that are for their own benefit: "one of the best ways to get people interested in immunization is a handy little epidemic or two!"

Wayne Corneil, who is an advisor with Health and Welfare on Employee Assistance Programs, spoke on the relative success of Occupational Health Nurses in contacting people who have alcohol problems. He noted that management often tended to view the health professional with suspicion, saying 'look at the bottom line!' It's up to nurses, he said, to tell management that you're both talking about the same thing, but in different ways. There is a move toward industrial hygiene and to counseling health in the workplace he said and he emphasized that nurses should take great care not to simply be caught up in this wave, but to place themselves

"in the vanguard". "You're the people with the know-how," he said, adding that nurses tended not to "blow their own horns" enough and that they should learn how to sell their programs to management.

Diane Hobbs, RN, BA, who is with the Addiction Research Foundation of Ontario, spoke on assisting the employee with an alcohol problem through personal contact or through organized programs. She stressed the importance of a sound knowledge base and the necessity for informed referrals. "Don't just send your people to a place: how would you like to be referred to something called The 28-day Program? Would you go?" She said there was no need for nurses to fear getting in over their heads if they made use of the various community resources available to them.

Next year OOHNA holds its tenth annual conference in London, Ontario. Executive elected at the 1980 conference are: Madeleine Wenman, president; Sue Arnold, 1st vice-president; Marilyn Fischer, 2nd vice-president; Sylvia Matchett, treasurer and certification co-ordinator; Gail Maginnis, membership chairman.

### Health happenings

The high intensity light of the argon laser has revolutionized treatment of the 'port wine stain' or hemangioma (see 'Surgical Tattooing' CNJ May '80). The blue-green light of the laser beam is finely focused upon the skin of the patient and absorbed selectively by the red pigment of the cells in the walls of the extra blood vessels in the skin. As the 'burned' skin heals, the red color disappears and is replaced by normal skin color.

*"Care for the caregiver", (October, CNJ) by Mary L.S. Vachon was based on The Laura Barr Lecture delivered by the author to the annual meeting of the Registered Nurses Association of Ontario in Toronto last spring. Credit for the original address, delivered in honor of the former RNAO executive director, was inadvertently omitted from the information on the author that appeared with the article.*





Photo by Zwicker, Content Magazine

**TWO NURSES, CNJ COLUMNIST CORINNE SKLAR** (left) and guest editorial writer Shirley Wheatley (right) were both winners in the Media Club of Canada's 1979 Memorial Awards competition. Above, they chat with national president Esther Crandall at the presentation ceremony in Toronto in October.

Shirley Wheatley, who is president-elect of the Registered Nurses Association of Ontario, was awarded first prize in the newspaper column or editorial category for her guest editorial on birth control in the teen years which appeared in the November, 1979 issue of CNJ.

Lawyer and former nurse Corinne Sklar received an honorable mention for her *You and the Law* column, "Sinners or Saints" in the November and December 1979 issues of CNJ.

CNJ Editor Anne Besharah also received an honorable mention for her editorial, "Who took the nurse out of nursing", that appeared in February, 1979.

### Help is as close as the phone

The Hospital for Sick Children in Toronto has recently expanded its Medical Information Service to allow for 24-hour coverage. Staffed by eight RN's and four clerks, the service is a three-part operation that includes Poison Control, Emergency triage and child-care information. Parents can call in for child-care information and answers to questions that range from "Should I bring my baby to hospital" to "What's normal growth and development?"

According to head nurse Judith Nielsen, most of the calls, which averaged 158 a day, are from parents whose children are acutely ill and who want to know what to do, or who need reassurance. "We're careful not to step over the boundary and give medical information," she says, pointing out that nurses do not recommend specific medication over the telephone,

rather, they inform the parents of home care measures.

The caller's name and information necessary for assessment is recorded on a profile sheet and parents who call about a child's illness are called back in a few hours to check on the child's progress. Most of the calls come in the evening hours when parents can't get in touch with their doctors or are afraid to bother them. "You'd be surprised at the number of mothers who really have no one to talk to," said Mrs. Nielsen.

Affiliated with Medical Information at HSC is the Family Information Service, a drop-in center in the hospital where parents can pick up pamphlets on any aspect of child care, read books on parenting or watch one of 50 videotapes. The focus is on preventing health problems says Ruth McCamus, RN, who presides in the center five days a week.

(continued on page 61)



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## Help for special services

Health and Welfare Canada has prepared a series of handbooks, *Guidelines for Establishing Standards for Special Services in Hospitals*. The booklets, which cover a number of services such as Total Parenteral Nutrition, Intensive Care Units, geriatric day hospitals and ultrasound facilities among many others, have set out guidelines for the establishment of such services. Included are recommendations for patient load, staff coverage, staff training and necessary equipment. For more information, or copies of the guidelines, contact *New Technology and Guidelines, Health Services Directorate, Health Services and Promotion Branch, Health and Welfare Canada, Ottawa, Ontario K1A 1B4*.

## A special place

Bloorview Children's Hospital is a very special place for children in Ontario who are chronically ill or handicapped. Bloorview promotes the team approach to care of these children, who suffer from cerebral palsy, muscular dystrophy, spina bifida and other crippling diseases or injuries, and under the hospital's administration the large professional

staff provides incentives to motivate each child to develop to his or her full potential. A film "Bloorview - A Very Special Place" has been commissioned to tell the hospital's story and is available without charge. Contact the distributor, Modern Talking Pictures, 143 Sparks Street, Willowdale, Ontario, M2H 2S5, or telephone 416-498-7290.

A series of 15 minute videocassettes on patient education topics have been produced by Robert Abelson of Ottawa. The film work was done on contract by CBC or the National Film Board; content was prepared in consultation with specialists in the specific fields.

The series has three different programs, each made up of 13 separate cassettes:

1. *Dentistry Today*
2. *Woman Talk* (on obstetrics and gynecology)
3. *Cardiology: You and Your Heart*.

These videocassettes are available for sale at a cost of \$200.00 per program, or to lease at \$99.00 per month. For further information contact:

*Take III Video Education  
Robert Abelson Company Inc.  
46 Elgin Street  
Ottawa, Ontario*

## The 1980 Health Computer

*Applications in Canada* contains over 250 pages of information valuable to any health facility. Its four sections give users the latest "who's who" in health computing, details of the hardware and software packages now in use, and describes over 350 accounts of individuals across the country getting maximum use out of their computers.

This sixth edition reference guide is available from:

*The Health Computer  
Information Bureau  
410 Laurier Avenue West  
Suite 800  
Ottawa, Ontario  
K1R 7T6*

Cost: \$50.00 in Canada  
\$65.00 outside Canada.

The Computer Bureau is sponsored by the Canadian Hospital Association, Canadian Medical Association and the Canadian Organization for the Advancement of Computers in Health.

## Maternity Care Checklist

The latest publication from the Canadian Institute of Child Health is *Family Centred Maternity and Newborn Care: A Resource and Self-Evaluation Guide*. Designed as an evaluation tool for units with more than 20 obstetrical beds, the guide is an aid to assessment of the quality of care being offered. In question and answer format, the guidebook can be used by nurses, physicians, hospital administrators or consumers.

A French edition will be released in the fall of 1980.

Copies are available from CICH, Suite 803, Laurier Avenue West, Ottawa, Ont. K1R 7T3, for \$10.00 each.

## Periodic health examination

Does preventive medicine really prevent disease and reduce the toll of disability and untimely deaths? This is the central question facing all health professionals, the public and all levels of government. A recent publication from the Canadian Task Force on the *Periodic Health Examination* provides an authoritative and reasoned review, and summary of published evidence. The price is \$18.50.

Other current publications are *Diagnosis and Treatment of Sexually Transmitted Diseases* (\$2.25) and *Health Protection and Drug Laws* (\$2.95).

Orders should be accompanied by a cheque or money order made out to the Receiver General of Canada and sent to Canadian Government Publishing Centre, Hull, Québec, K1A 0S9. ☛

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Although most of our knowledge about the blood clotting mechanism has been acquired since the 18th century, the phenomenon of liquid blood being converted to a solid gel must have been familiar to primitive man. Some of the earliest recorded observations were left by Aristotle who made extensive study of the subject. His observations, recorded in *Historia Animalium*, show he recognized that the clotting process was dependent upon the watery portion of blood which he called serum. He was also aware of marked differences in the blood clotting ability of various species and in diseased and healthy human beings. These observations and deductions, remarkable for his time, were later substantiated by investigators with more sophisticated equipment such as a microscope.

# Hemostasis and the nature of its defect in hemophilia

Anne Hedlin

Cuts and bruises are common occurrences in our daily lives and we pay little attention to them because experience has shown us the bleeding will stop with little or no treatment. Obviously we possess some efficient mechanisms capable of preventing blood loss which are rapidly activated in response to blood vessel injury. Hemostasis, the process concerned with the prevention of blood loss, involves the combined activities of blood vessels, platelets and the coagulation mechanism. Each of these makes a unique contribution, the extent of which depends on the severity of the injury and the number and size of the blood vessels involved.

## Vascular response

When a blood vessel is injured, such as by a blow or a cut, it immediately constricts; that is, it undergoes vasospasm. This response helps to reduce blood loss by decreasing the flow of blood to the area. Vasospasm makes an important contribution to hemostasis as it can occur in all types of vessels and may be of sufficient intensity to completely occlude the vessel. This constriction is prolonged by substances released by those platelets which react to the vessel injury.

## Platelet action

Platelets, non-nucleated cell fragments, are formed in bone marrow from megakaryocytes, which extrude a portion of their cytoplasm into a blood vessel where it becomes pinched off. They are usually discoid in shape but can form pseudopodia (finger-like processes) which are contractile (*see figure one*).

Platelets are normally present in a concentration of about 250,000 per cubic millimeter of blood. If their number falls to below 20,000 per cubic millimeter, a serious bleeding tendency develops. This bleeding may take the

form of petechiae (tiny hemorrhages in the skin) and oozing from intact mucosal surfaces.

Platelets do not normally adhere to the smooth intact endothelium of blood vessels; when the vessel wall is damaged, however, they are exposed to underlying connective tissue containing collagen to which they do adhere. This adhesion of platelets to collagen triggers the release of platelet adenosine diphosphate (ADP) which promotes adhesion of platelets to each other. Collagen and ADP induced adhesion together result in the formation of a platelet plug; in tiny vessels this plug will seal the opening and prevent bleeding. Adhesive platelets also release chemical vasoconstrictors, such as serotonin, which prolong the constriction initiated by the vasospasm; this assists in the formation of the platelet plug. The combined effect of the vascular response and platelet plug formation will halt the flow of blood from vessels temporarily, but if a fibrin clot does not form to hold the platelets in place, they will be washed away when the vessel relaxes.

## The coagulation mechanism

Most of the substances necessary for clot formation are present in the blood,

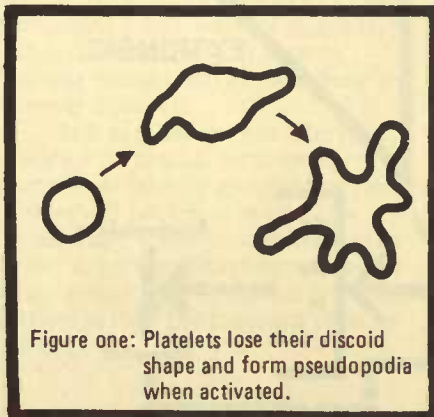


Figure one: Platelets lose their discoid shape and form pseudopodia when activated.



but because these factors are in an inactive form, blood does not normally clot in the vessels. These clotting factors will be activated when blood comes in contact with a "foreign" surface such as a rough vessel lining, other damaged tissues, or an object like a syringe, needle or glass tube. The process is called intrinsic clotting if it uses only the substances found in the blood; when it involves the contribution of substances found in surrounding tissues it is called extrinsic. Bleeding from a severed vessel initiates both intrinsic and extrinsic clotting mechanisms (see figure two).

#### Intrinsic coagulation

When blood comes in contact with a foreign surface, Factor XII is activated to Factor XII<sub>a</sub>. This activated factor sets off a cascade of reactions when in turn it acts on Factor XI. Factor XI then causes Factor IX's activation and together with Factor VIII, calcium ions, and a phospholipid contributed by platelets, brings about activation of Factor X.

Activated Factor X then enlists the assistance of Factor V, calcium ions and platelet phospholipid to convert the plasma globulin prothrombin to an active proteolytic enzyme, thrombin. Finally, thrombin acts on another plasma protein fibrinogen; it attacks certain bonds in the fibrinogen molecule, producing fragments known as fibrin monomers. These monomers attach end-to-end, forming long tangled chains in which red blood cells are trapped.



Photo courtesy Health and Welfare

The resulting mass of fibrin and cells assumes the appearance of a gel. The liquid portion of the clotted blood, known as serum, is squeezed out of the gel during clot retraction.

#### Extrinsic coagulation

When blood escapes into the surrounding tissues, a substance called tissue thromboplastin or tissue factor forms a complex with Factor VII. This complex in the presence of calcium ions, activates Factor X and from this point the action proceeds as for intrinsic clotting. Because this process requires the action of a substance found outside the blood it is called extrinsic clotting.

#### Prevention of clot formation

Obviously, this clotting mechanism is potentially harmful; if clots form within the blood vessel and obstruct blood flow in a vital area such as the heart or brain, the individual's life is endangered. Fortunately, in addition to the fact that the clotting factors are in an inactive form there are both natural and artificial methods of preventing blood coagulation. Normally, the smooth endothelial lining and a layer of negatively-charged protein on the inner surface of the vessel reduce the possibility of clotting through contact activation. Also, the blood contains inhibitors to the active factors, which, if activation does occur can sometimes prevent coagulation by their interaction, e.g. antithrombin interacting with thrombin.

To maintain the liquid form of the blood *in vitro*, anticoagulants may be added, or one of the essential clotting factors can be eliminated, neutralized or inhibited. To preserve blood for transfusions or for hematological purposes an anticoagulant such as sodium citrate is added to it. The citrate combines with calcium ions, thereby preventing them from contributing to the clotting process. (Calcium must be in the ionized form to promote clotting.) Once sufficient sodium citrate has been added blood will remain liquid indefinitely, unless calcium ions are added again to restore clotting ability.

Procedures involving extracorporeal circulation require the use of artificial anticoagulants. In open heart surgery or the use of the artificial kidney when the patient's blood must circulate through a network of tubing outside the body, these artificial vessels provide a "foreign" surface contact. If an anticoagulant, in this case heparin, were not added the blood would clot. Heparin prevents clotting by interfering with the action of several blood factors; it is ideal for these treatments since its anticoagulant effect is immediate in the artificial system and it is subsequently rapidly inactivated in the patient's circulation.

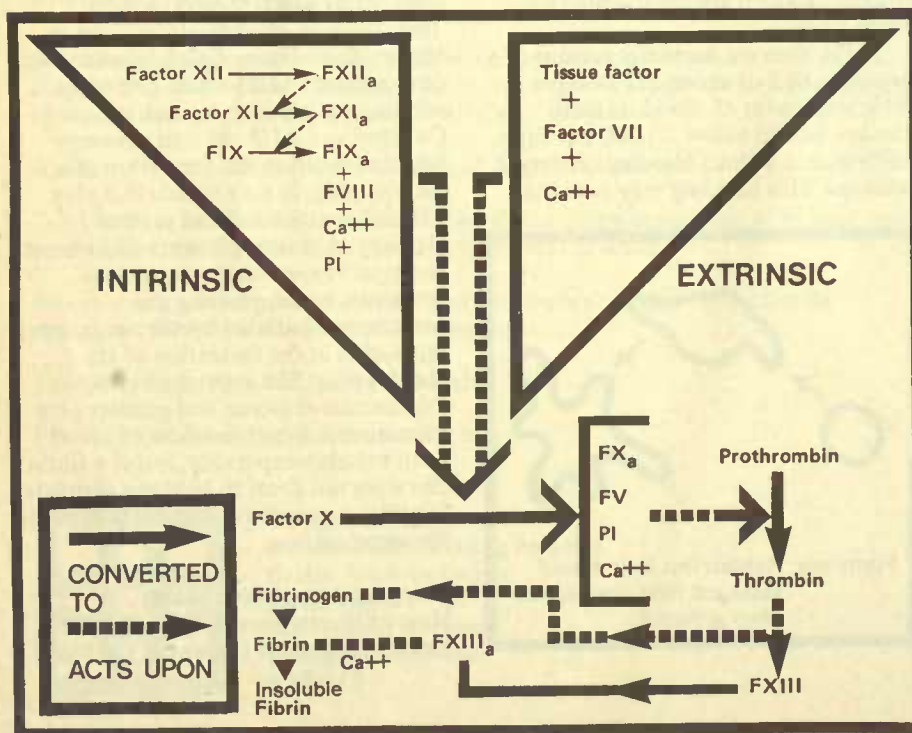
#### Fibrinolytic mechanism

A clot once formed is still susceptible for a short period, to dissolution by the action of plasmin, a proteolytic enzyme. Plasmin is formed from plasminogen by the action of specific activators in the blood and tissues. It attacks the fibrin molecules of the clot breaking it into small fragments thereby dissolving or lysing the blood clot.

#### Bleeding disorders

Blood coagulation is in part the result of a chain reaction; a weak link in this

Figure two: The activation of blood coagulation factors which results in conversion of blood from a liquid to a gel.





chain can cause a serious delay in clot formation. Perhaps the best known bleeding disorder is hemophilia, the commonest form of which is classical hemophilia resulting from a deficiency of Factor VIII. The term hemophilia is also used for deficiencies of Factors IX and XI which occur less frequently.

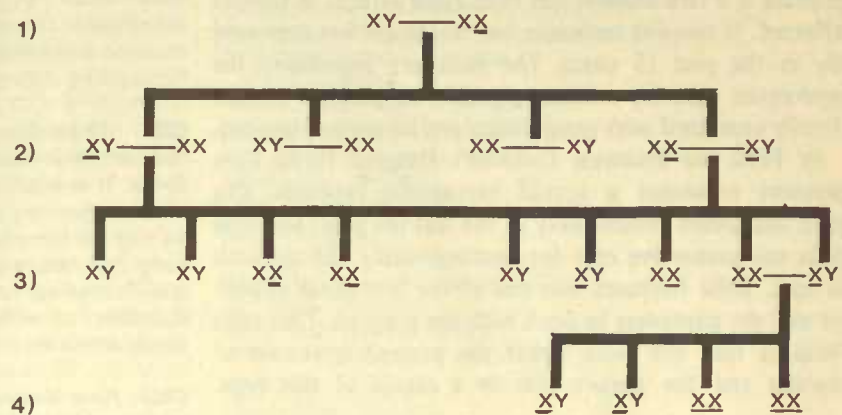
Classical hemophilia is characterized by a sex-linked recessive inheritance of a hemorrhagic tendency which affects males almost exclusively. The defect is transmitted to the affected sons by the X-chromosome of the carrier mother. The carrier usually is symptom-free, but may bleed abnormally following childbirth or surgery. Although hemophilia is limited almost exclusively to males, symptoms of the disease have been known to occur in the female child of a hemophiliac father and carrier mother (see figure three). Female hemophiliacs, however, are rare.

The earliest manifestations of this condition occur in early childhood, not necessarily as might be expected, in the neonatal period. Even severely hemophilic babies may appear to be normal for the first six to nine months of life except for excessive bruising. It is suggested that during this time the combined effect of Factor VIII derived from the mother, and the typically protected life of the infant reduce the possibility of bleeding. Once the child begins to crawl and walk, however, the inevitable falls and blows cause bleeding into tissues.

Hemophilic blood clots slowly. Whole blood clotting time for a hemophiliac may be several hours as compared to the normal time of 5-8 minutes. Because of this delayed clotting time the large hematoma characteristic of hemophilia may form as a result of a minor injury. Without effective treatment bleeding can continue for days or weeks from slight injuries. If extensive bleeding occurs repeatedly into muscles and joints the results will be not only pain and swelling but also muscle contracture and joint deformity.

Hemophilic individuals do not normally bleed excessively from superficial cuts because the normal forces of their hemostatic system, namely vessels, platelets and extrinsic clotting, may be sufficient to seal the wound and stop blood loss. For example, the hemophiliac's bleeding time test is usually normal. However, when bleeding is sufficient to overwhelm these components of the hemostatic system, the delayed intrinsic clotting of the hemophiliac places him in danger of uncontrolled hemorrhage.

Figure three: The heredity pattern of hemophilia. The defect is carried by the X chromosome. The offspring of a female carrier and normal male may be normal, a female carrier or hemophilic male. Mating of two individuals who each possess the defect may, in the extreme case of a hemophilic male and hemophilic female, result in exclusively hemophilic offspring (Generation (4)).



Uncontrolled hemorrhage into tissues in the hemophiliac suggests the presence of a defect in extrinsic coagulation. However, even in the normal system extrinsic coagulation is not capable of controlling blood loss from vessels but requires the assistance of the intrinsic. The delayed intrinsic clotting allows large volumes of blood to escape.

Methods used to halt bleeding in the individual with normal clotting time are ineffective in the hemophiliac who requires administration of the defective clotting factor, e.g. Factor VIII. If treatment is instituted promptly, not only can the bleeding be controlled but deformity can be greatly reduced or prevented.

Factor VIII deficiency hemophilia is perhaps the best known bleeding disorder, but there are others. The Factor VIII defect in von Willebrand's Disease, defects of Factors IX, XI and fibrinogen, a deficiency of platelets, and excessive activity of plasmin (causing fibrinolysis) all contribute to bleeding disorders.

It is easy for the one who is blessed with normal hemostatic function to take for granted that minor injuries will not result in a serious hemorrhage. Those who suffer from a defect in hemostasis are acutely aware of the importance of normal hemostatic activity as they live from one crisis to the next. ♡

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# A Special Hemophilia Program

Gail O'Neill

Hemophilia is a rare disease; less than 2000 persons in Canada are affected. It remains incurable but treatment has improved greatly in the past 15 years. The necessary ingredients for comprehensive care are a knowledgeable, cooperative patient and family combined with good clinical and laboratory services.

In 1970 the Montreal Children's Hospital Home Care Department organized a special hemophilia program. The program has grown considerably in the last ten years and now provides comprehensive care for approximately 160 patients of all ages. Delia Kermack was one of the first nurse coordinators and she continues to work with the program. CNJ talks to Delia to find out more about the present treatment of hemophilia and the nurse's role in a center of this type.

**CNJ:** *Could you explain the origin of the program?*

**Delia:** The Montreal Children's Hospital started a home care program for chronically ill children in 1964 with a staff of one nurse and one doctor. In 1970, a decision was made to expand the program to include children with hemophilia who were frequently admitted to the hospital. At this time, we had 40 to 50 children with this disease.

**CNJ:** *Were there changes in treatment around this time?*

**Delia:** Up until 1965, patients were treated with plasma infusions. In the late 1960's it became possible to replace the missing clotting factor in classical hemophilia with cryoprecipitate, a plasma derivative rich in Factor VIII. This was made available through the Red Cross and it was a major breakthrough in treatment.

**CNJ:** *Is cryoprecipitate the only new treatment product?*

**Delia:** No; to discuss treatment further we must distinguish the types of hemophilia. The two major forms are hemophilia A (factor VIII deficiency or classical hemophilia) and hemophilia B (factor IX deficiency or Christmas Disease). The basic treatment for both A and B is to replace the missing factor. Fresh frozen plasma contains both of these factors, but there are many side effects such as frequent allergic reactions and hypervolemia. Commercially prepared freeze dried concentrates of both factor VIII and IX became available in the 1970's. The freeze dried concentrate is reliable, easy to use and store in homes, schools or offices and convenient for transport by the traveller.

**CNJ:** *How is the choice made between cryoprecipitate and the dry concentrate for those with factor VIII deficiency?*

**Delia:** It is possible that either one is used under different circumstances. For example, cryoprecipitate is a single donor infusion and it is recommended for mild bleeders and young children because of the reduced risk of hepatitis. The concentrates are much more effective though, and ideal for home infusion.

**CNJ:** *What are the problems and side effects of these treatments?*

**Delia:** The problems are those normally encountered in intravenous infusions and the use of blood products. The long term effects are unknown. We are now concerned about the growing number of patients with abnormal liver function tests and this may be one of the side effects.

**CNJ:** *What are the major dangers for the person with hemophilia?*

**Delia:** The vascularity of the tissue and the body cavity or area determine the dangers of the hemorrhage. Bleeding into the central nervous system, into the neck, chest cavity or the abdomen require immediate treatment and hospitalization. These incidents are uncommon in most individuals but when they occur a knowledgeable patient and family is very important. On the other hand, frequent hemorrhages into muscles and joints without good treatment leads to progressive hemophilia arthropathy and crippling.

**CNJ:** *What does comprehensive care for the person with hemophilia involve?*

**Delia:** It is equivalent to the care of any person with a chronic illness: they require services and support that will allow them to live as normally as possible with their disability. Specifically this means prompt treatment of acute bleeding episodes and follow-up care. Continuous patient education and good coordination with other services is mandatory if all health care needs are to be met adequately.

**CNJ:** *How does this program provide for comprehensive care of chronically ill patients?*

**Delia:** We are a multi-disciplinary team consisting of physicians, nurses, physiotherapists, social workers, occupational therapists and secretaries. We provide 24-hour on-call coverage. Our consultant staff include hematologists, orthopedic surgeons, internists, dentists, geneticists and psychiatrists.

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**François, born in 1949, was the second of three children in a family with no history of hemophilia. When he was circumcized one week after his birth he bled excessively and as a result remained in hospital for a month. A year later he was diagnosed as having severe classical hemophilia but he did not have any serious problems until he was two. From two until his early teens he was hospitalized on an average of 15 times a year. Hemarthroses, his major problem, was treated at that time with whole blood, fresh frozen plasma, joint aspirations, casts, traction, physiotherapy, and codeine or aspirin for pain. At five a cerebral hemorrhage put him in a coma for three days but he made a good recovery in time. An appendectomy at seven was complicated by an evisceration requiring more surgery; during his recovery François remembers being tied to the bed with IV's running in both arms, sometimes whole blood and other times plasma. At 11, the year he had cobalt radiation for his tonsils, he was sent to a school for the handicapped where he stayed for seven years. From 16 to 18 he was treated in the emergency department two or three times a week for various hemarthroses and required hospitalization four to six times a year on an average. Most of his admissions were short stays of three to six days, but in 1976 he spent 300 days in hospital because of poor response to treatment. Dental work was only done once in ten years.**

**Most of François's bleeding episodes caused extreme and prolonged periods of pain. He believes that this chronic pain was not treated adequately because of fear of addiction and that this may have contributed to some of his problems such as anxiety, depression, obesity, headaches and a duodenal ulcer.**

**In 1977 at the age of 28 he was admitted to the Home Care Program and taught the self-infusion procedure so that he could treat his bleeds immediately. He also underwent extensive dental work at this time using local anesthesia and factor VIII coverage. The frequency of his bleeding episodes remains high but control is good. Pain is still very much a problem but it is modified by mild analgesics. Hospitalizations have almost become a thing of the past.**



**CNJ:** *What is the nurse's role in this program?*

**Delia:** The nurse assesses and treats acute bleeding episodes and coordinates the acute and chronic care for these patients: she really provides primary care. She is responsible for patient and family education including the disease, treatment, IV infusion techniques and genetic counseling. She also acts as a liaison with schools and employers. Education of other hospital staff, including the emergency department, is another important function. The nurse participates as well in any hemophilia research the centre may be involved in.

**CNJ:** *What other resources exist for the person with hemophilia?*

**Delia:** The Canadian Hemophilia Society, a voluntary non-profit consumer organization, has been in existence since 1953 and now has a chapter in every province. The society works toward solving the problems of this disease by helping patients and families, ensuring the effective use of national blood resources and striving for the eventual cure and elimination of the condition. The society is a charter member of the World Federation of Hemophilia. At Montreal Children's Hospital, as at other special Canadian treatment centers across the country, it is the nurse coordinator who acts as a liaison person between the clinic and the Hemophilia Society. Nurses who wish to obtain more information about the work the society is doing should write to:

The Canadian Hemophilia Society  
Chedoke Centre Patterson Building  
P.O. Box 2085  
Hamilton, Ontario L8N 3R5  
Executive Director: Edwin Gurney

*John, a ten-year-old boy from a family with a history of hemophilia, was diagnosed at eight months of age after a hemorrhage into his hand. He was immediately referred to the Home Care Program and the nurse made frequent home visits to teach the family about the disease and its management. Being an active toddler he bled frequently into muscles and joints and these episodes were treated at home by the home care nurse. On weekends and after hours his mother would contact home care and arrangements would be made to have his treatment ready for his arrival at the emergency room. As soon as his veins were more easily accessible, his mother was taught intravenous infusion technique, so from age three she treated him for all minor bleeding episodes. The family was supported by telephone contact during the early days of home infusion and they quickly achieved independence in day-to-day management. Time was no longer lost in travel and this immediate treatment shortened the duration of the hemorrhages.*

*John was hospitalized six times between the ages of two and six; four times for minor head injuries, once for a tongue laceration, and once for a synovectomy of his left ankle. When he started school the home care nurse met with school personnel to discuss hemophilia and its management. Since the age of six he has averaged about 35 bleeding episodes a year each requiring a day or two of treatment; he receives factor VIII concentrate and occasionally must wear a splint for joint immobilization. His primary care is under a pediatrician and he sees an orthopedic surgeon for his chronic left ankle problem. Dental examination and care is routine at least twice a year and he has a total evaluation yearly at the home care assessment clinic.*

*John leads a relatively normal life and is now in grade five of a French immersion program; he rarely misses school. He is an excellent swimmer and enjoys his guitar lessons.*

## Special Canadian Treatment Centres for Hemophiliacs

**British Columbia**  
Hemophilia Assessment Clinic  
The Arthritis Centre  
Vancouver, B.C.  
Nurse Coordinator: Lois Lindner

**Alberta**  
Comprehensive Assessment Clinic and  
Home Care Program for Hemophiliacs  
Alberta Children's Hospital  
Calgary, Alberta  
Nurse Coordinator: Cathy Bennett  
Comprehensive Hemophilia Centre  
University of Alberta Hospital  
Edmonton, Alberta  
Nurse Coordinator: Carol Zittlau

**Saskatchewan**  
Hemophilia Treatment Centre  
Elliss Hall Patient Education Centre  
University Hospital  
Saskatoon, Saskatchewan  
Nurse Coordinator: Caryl Bell

**Manitoba**  
Hemophilia Program  
Health Sciences Centre  
Winnipeg, Manitoba  
Nurse Coordinator: Myrna Deagon

**Ontario**  
Hamilton Regional Hemophilia Program  
McMaster University Medical Centre  
Hamilton, Ontario  
Nurse Coordinator: Brenda Blair

Southwestern Ontario Hemophilia Centre  
St. Joseph's Hospital  
London, Ontario  
Nurse Coordinators: Matthew Maynard, Alison Currie

Hematology Clinic  
Hospital for Sick Children  
Toronto, Ontario  
Nurse Coordinator: Clair Smith  
Ottawa General Hospital  
c/o Dr. Smiley Office  
Ottawa, Ontario  
Nurse Coordinator: Claire Brodeur  
Toronto Auxiliary Children's Hospital  
Toronto, Ontario  
Nurse Coordinator: Sylvia Simpson

**Québec**  
Home Care Program  
Montreal Children's Hospital  
Montréal, Québec  
Nurse Coordinators: Delia Kernack, Ann Lynch, Gisèle Bélanger, Dona Johnston, Margaret Hall

Hemophilia Program  
Hôpital Ste-Justine  
Montréal, Québec  
Nurse Coordinator: Muriel Girard

Centre Hospitalier Universitaire  
Département d'Hématologie  
Sherbrooke, Québec  
Nurse Coordinator: Lucie Biron

Hôpital St-Sacrement de Québec  
Centre d'Hématologie  
Québec, P.Q.  
Nurse Coordinator: Evangeline Morin

**Newfoundland**  
Hemophilia Program  
Dr. Charles Janeway Child Health Centre  
Saint John's, Newfoundland  
Nurse Coordinator: Irene Walshe.



# Primary Nursing?

Do patients like it  
Are nurses satisfied  
Does it cost more

Laverne E. Roberts

The concept of "primary nursing" was developed in the late 1960's as a result of general dissatisfaction among nurses with fragmentation of patient care and lack of a professional level of nursing practice within hospital settings. Since then, it has spread widely across the U.S. and Canada and has been the object of numerous research studies. The nursing department of the Victoria General Hospital in Winnipeg implemented the concept of primary nursing on one unit as a pilot project to compare its effectiveness to the system of "team nursing" used throughout the institution.

## Formulation of the study

Our search of the literature revealed that usually, when primary nursing is implemented, quality of care increases. Most of the available information

though is based on studies conducted in the United States, the majority of them focused on the underlying objectives of primary nursing. What we sought to do was to replicate these positive findings in a Canadian setting, using the following variables as a measure of effectiveness:

- continuity of care
- individualization of care
- patient satisfaction

- staff nurse satisfaction, and
- operating costs.

The established system on most nursing units in the 254-bed Victoria General Hospital is *team nursing* (also called 'total care' nursing) in which a group of nurses (RN's and LPN's) function under the direction and coordination of a team leader. Each nurse is individually assigned to a



Photo courtesy Montreal General Hospital



number of patients for that particular shift during which she gives total "hands on" nursing care. Assessment, planning and evaluation of the care of those patients is the responsibility of the team leader who shares these responsibilities at her discretion with the other nurses on her team. The team leader coordinates the patient care and communicates with other members of the health team.

*Primary nursing*, on the other hand, is defined as "a system of delivering nursing care in which each patient is assigned to the care of a primary nurse (registered nurse). This nurse, in collaboration with the patient, family and other members of the health team, plans, implements and evaluates the patient's nursing care from admission to discharge."<sup>1</sup> Each primary nurse is responsible for a caseload of four to five patients and is accountable for their nursing care on a 24-hour basis. The associate nurse (another RN or LPN) provides care in the primary nurse's absence, following her directions. The primary leader (the equivalent of a head nurse) provides quality control for the care given to all patients on the unit and acts as a resource person for the primary nurse.

We adopted the elements of primary nursing as developed by the University of Minnesota Hospitals to further define the concept:

- a basic one-to-one patient relationship
- decentralization of decision-making for patient care to the individual nurse
- clear allocation of responsibility and authority for nursing decisions
- 24-hour total nursing care planning by the primary nurse for assigned patients
- direct communication between primary nurse, associate nurses and other disciplines caring for the patient
- inclusion of the patient and family in planning care.

#### Methodology

In order to implement primary nursing within a research design, in February, 1978 we divided our acute care medical unit into one 24-bed experimental unit and one 24-bed control unit. The control unit continued to utilize team nursing, while the experimental unit implemented primary nursing.

Three instruments were used in the study to determine effectiveness of nursing care on each unit:

1. *a patient questionnaire*, which contained 20 items, looked at the patient's perception of the continuity of his care, how individual he thought it was and his degree of satisfaction with this care.

2. *a job satisfaction inventory*, designed to be especially sensitive to differences in nursing care delivery systems. Developed by Peterman and Schauwecker as part of the Western Interstate Commission for Higher Education nursing research project, the questionnaire contained 48 items which measure certain factors contributing to job satisfaction.

3. *a patient record audit*, developed by the author specifically for this study, which examined the directions given by the care planner on the nursing care plan and measured how closely those directions were followed by other care givers.

Operating costs were studied in relation to baseline staffing, differences in sick time, and in unscheduled overtime. Since both the primary and the team nursing unit functioned financially as one entire unit on one approved budget, other statistics were almost impossible to identify. The statistics used were obtained from records kept by the unit director for a period when both primary and team nurses were on identical rotation schedules.

#### Findings

Our findings were interesting:

- First, the patient records demonstrated that there was slightly more continuity of care on the primary nursing unit. Responses to the patient questionnaire also indicated that there was more continuity of care on the primary unit, and that this care was more individualized, *but* patients from both units were equally satisfied generally with the care they received.
- Primary nurses on the other hand were more satisfied with their job than were the team nurses, except in relationships with physicians.
- Finally, no increase in costs was incurred as a result of dividing the unit into team and primary nursing sections; both functioned at an *equal cost* in relation to baseline staffing, unscheduled overtime and sick time.

#### Discussion

Recording that nursing care has been implemented as directed on the nursing care plan is probably a good indicator of continuity of care, and the study results showed that the nursing care plan was followed more often on the primary unit: 57.7 percent of nursing orders were recorded as implemented, as opposed to 39.6 percent on the team unit.

The primary nurse has the responsibility of both planning and directing the patient's care, and of ensuring that care is carried out in a consistent manner by her associate nurses, chiefly through use of the nursing care plan. If the care is not given as directed, the primary nurse has the authority to investigate the reasons. This authority and accountability among peers may well explain why the nursing staff followed the care plans more often on the primary unit.

Another factor that may have influenced the difference in results between the two units was that the primary nurses had been oriented to the nursing process which involves a systematic approach to nursing care planning. This approach emphasizes specificity; the more specific the nursing care plan, the less open it is to individual interpretation, and the more easily it can be followed.

These two factors, the authority/accountability of the primary nurse and the use of the nursing process are highly interdependent. The primary nurse needs to use an approach to patient care that will clearly identify her personal accountability; however, as Carlson states, "many graduate nurses are unable to utilize the theory (of nursing process) due to the fact that we are still using mass production techniques, rather than a primary nursing concept in our delivery of nursing care."<sup>2</sup>



It is interesting to note that both units rated lower in following nursing orders than might be expected — neither 57.7 percent nor 39.6 percent is a high percentage. Either nurses were not recording what they were doing or they were not following the nursing care plan. One can only speculate on an explanation: the hospital's guidelines for documenting nursing care were unclear and open to misinterpretation so that methods of recording may have been inconsistent, or, as the literature on nursing process often comments, many nurses feel that nursing care plans are useless or unimportant and as a result, do not use them. (Do nurses feel that way due to a poor self-image, reflecting a history of subservience and their current difficulty in adjusting to independent practice?)

The fact that the primary nurse herself cares for her patients each time she is on duty also contributes to continuity of care. She informs her patients of her schedule and of the associate nurses who will be caring for them in her absence. The responses on the patient questionnaire indicated that the patients on the primary unit were more often able to identify which nurse would be looking after them from one shift to the next and felt the nurses were more aware of what happened on previous shifts. When the patients were asked how often something was omitted from their care that they had expected the nurse to do, the primary patients identified fewer omissions than the team patients.

When patients were queried regarding their perception of individualization of nursing care, the primary patients more often felt the information they shared was being used by the nurse to help her care for them. The continuity of the nurse-patient relationship in primary nursing likely contributes to this feeling. It is also interesting that primary patients perceived that the nurses talked to their families about their care more often than did team patients; this is one of the basic elements of primary nursing — the inclusion of patient and family in planning care.

Figure one: Variations in job satisfaction, primary and team nurses

	Primary Nurses (N = 5) Mean Score	Team Nurses (N = 4) Mean Score
Accomplishment	2.8	2.8
Workload	2.8	2.6
Head Nurse	3.0	3.0
Physician	2.5	2.8*
Administration	2.9	2.8
Decision-making	3.3	3.1
Recognition	3.2	2.8*
Utilization of knowledge and skills	3.2	2.9*

\*Significant differences

Despite all the positive results received from the primary patients versus the team patients, when we asked how satisfied they were with nursing care, there was little difference in their responses. Obviously, not all the variables that influence patient satisfaction were tested in this study. Why do patients answer items negatively in relation to what nurses would consider quality care and then turn around and say they are satisfied with that care? What are the public's expectations of nursing? It was hoped that the two open-ended questions that asked what patients liked best and least about their nursing care would shed some light on this mystery, but while almost all patients answered the "liked best" question, very few of them responded to the "liked least" question. What they liked best about the nursing care was similar on both units, i.e. characteristics of the nurse such as pleasantness, concern, friendliness, etc., described by both groups.

Another variable that we examined was job satisfaction. As discussed earlier, one of the reasons for developing the primary nursing system was a lack of professionalism in hospital nursing. Primary nursing attempts to give the staff nurse a high degree of autonomy, authority and accountability in practice; nurses on the primary unit indicated on the job satisfaction inventory that they had more opportunity for using their knowledge and skills (See figure one). Throughout their education, nurses learn to assess, plan, implement and evaluate the nursing care of the patient but often,

when they begin working in a hospital setting, they are not given the opportunity to use the full range of these skills. Primary nursing supports independent decision-making; the care giver is the care-planner.

Another significant finding of the inventory was that the primary nurses felt they received recognition of their work not only from immediate supervisors, but from patients, peers and other members of the total health care team. Of course, this may have been due to the fact that these nurses were spotlighted by the study, but some consideration must be given to the rewards of primary nursing.

By contrast, the scores on items asking nurses about their relationship with the physicians were higher for the team unit than the primary unit. We had predicted the opposite because the primary nurses have one-to-one contact with the physicians on a daily basis, whereas the team nurses have only sporadic contact with physicians, and because during their orientation and throughout the development of primary nursing, the nurse-physician colleague relationship had been emphasized a great deal. Perhaps the primary nurses expected immediate changes in those relationships and when only the amount of contact rather than the nature of the relationship changed they became discouraged. The traditional handmaiden image is difficult to discard and the desire for change may seem to be one-sided.



The cost of primary nursing is of great concern to administrators; it is commonly thought that primary nursing costs more. However, neither current literature nor our study support this. The change to primary nursing need not cost more *providing that staffing is already adequate*. As Ciske reminds us, "If requests must be made for more and higher quality staff to ensure quality care, then the request is valid, no matter what organization is chosen."<sup>3</sup> No increase in costs was incurred as a result of dividing the unit into team and primary nursing. The total number of equivalent full-time positions (EFT's) before dividing the unit equalled 28.8; when primary nursing was introduced, this figure increased to 30.5 EFT's. At the time, the increase seemed unavoidable as working with two smaller rotation schedules usually costs more, but with some streamlining, that figure was reduced to 27.4 and again to 27.1, finally stabilizing at 27.2 EFT's. Unscheduled overtime for the entire unit (primary and team) was negligible and sick time during the two-month period when both primary and team staff were on identical rotation schedules was equal.

Our conclusion that primary nursing is at least as effective as team nursing and, in fact, *more* effective in terms of continuity, individualization of nursing care and staff satisfaction, suggests that the primary nursing concept is a justifiable alternative to the team system in the described clinical setting. Other studies in the U.S. have supported the effectiveness of primary nursing in a variety of settings but consideration must be given to the fact that differences in the health care system between that country and Canada make it difficult to project these findings to any individual Canadian institution. Further study is needed to replicate these findings in other settings. ♡

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## Did you know...

Between 1972 and 1978 there has been an 822 percent increase in Ontario Workmen's Compensation Board claims as a direct consequence of noise. Noise-induced hearing loss, which is 100 percent *preventable* and 100 percent *incurable*, results in permanent nerve damage to the ear and also contributes to high blood pressure, tension, nervousness, headaches and even ulcers. Dr. David Naiberg, Chief of Otolaryngology at Scarborough General Hospital, cites an effective hearing conservation program as a way to reduce these claims but says that one of the biggest obstacles is employee education. Correct use of protective measures, such as ear muffs must be stressed; ventilating them with holes or just hanging them around one's neck are common practices. Naiberg claims that employee absenteeism is reduced and workers' efficiency increased when noise pollution is decreased.

## Did you know...

In the first 41 weeks of 1979, 21,726 cases of measles were reported in Canada, i.e. 250 per 100,000 persons under 20 years of age, an increase of 460 per cent over the comparable period in 1978. However, in the United States, where legislation requiring measles immunization before or at the time of school entry has been passed in 50 states, only 12,353 cases or 18.5 cases per 100,000 persons under the age of 18 years were reported in the same period. This is 50 per cent lower than their figures in the corresponding period in 1978 and 75 per cent lower than the 1977 figure.

While measles is often considered to be a viral disease of little importance, statistics show that one in 15 sufferers have complications of pneumonia or otitis media, about one in every 1000 develops encephalitis and about one in every 10,000 dies.

## Did you know...

Dentists warn mothers of infants against the Nursing Bottle Decay pattern of tooth decay, which may occur in children between the ages of one and four years. The chief cause is leaving a bottle in bed with a child: the constant washing of sweet fluid (and this can be juice, soft drinks, or even milk) over the teeth and gums results in a build-up of acid which weakens tooth enamel, exposing it to decay.



# THE POSTPARTUM PERIOD

## What is reality?

*Constance Becker*

Nurses who provide care to the maternity patient are aware of the move to more comprehensive patient-centered care; some changes have occurred, but does current management and patient teaching match the hard reality of the patient's own experience?

Part of the reality of the postpartum experience is that clients and health professionals alike have made several assumptions about it. They are:

- the puerperium is a healthy — not unhealthy or diseased — state.
- the transition for both parents from expectant to actual parenthood is smooth and natural.
- the postpartum period lasts six weeks.

The first assumption is based on the broad experience that most women have a good outcome from pregnancy and a medically uncomplicated puerperium. From a medical point of view this may be realistic, but if one's definition of health encompasses more than physiological function to include emotional and social function, then the assumption is not accurate. Neither is it accurate to assume that the transition to parenthood is uncomplicated — the reality is that for many new parents problems and stress result. Thirdly, while a woman's body may have assumed its

pre-pregnant state on the whole, her emotional and social functioning cannot have adapted in such a short time. Is the concept of the 'fourth trimester' merely a concept or is it an actuality in patient care?

If, as one researcher has said, childbearing is a multidimensional experience,<sup>1</sup> then it requires a multidimensional approach, one that deals with the reality of the postpartum experience as it is for most new parents, and which dispels those myths to which many patients and health professionals subscribe.

### Learning the role

Why is learning the new mother and new parent role so problematic? Four factors which affect the transition are:

1. the lack of a cultural option to reject parenthood,
2. the fact that marriage no longer constitutes a major transition point in a woman's life,
3. the abruptness of the change, and

4. the lack of realistic guidelines for successful parenthood.<sup>2</sup>

An individual who is learning a new role in life generally learns something about that new role before she or he has to assume it: as student nurses, for instance, we learned something of our role functions before we became graduate nurses. The less role clarification one needs after assuming the role, the less difficulty one encounters in making the transition and in functioning effectively. Bearing these thoughts in mind, we may ask ourselves — do women and new parents learn enough about their new role beforehand? Do they receive adequate clarification? What can nurses do to help?

The role of new parent can be learned and clarified in several ways; people may observe their own parents or peers functioning, but often they believe they will operate differently — "I'll never do that the way my parents did with me."



They learn from the media too but the style of parenting presented on TV or in the movies is unattainable and unreal for most viewers. More often than not the new mother is given the picture of a 'supermom' who presides over an immaculate home, looks like a fashion model, whose children are well-behaved and never fight, and who has lots of spare time to spend in leisure activities with her spouse and offspring. Magazine or newspaper articles or pamphlets may provide conflicting information, thus confusing parents. Worse, the information given by health professionals may contradict that presented in the media.

A new mother may also gain information on her role function through clarification with her mate but this too can be problematic for several reasons. First, men generally expect women to know how to care for an infant and as they see the function to be inherently female they may provide no real feedback. The reality here is that the so-called maternal instinct may be a comfortable male myth; believing in it, a man can abdicate all responsibility for infant care to the woman. But belief in the myth is not exclusive to males: women believe it too. How often is the new mother told in answer to a question, "Just relax and do what comes naturally." Some well-meaning people may tell her to have her husband take on some of the infant care or home-making activities without realizing that there are those who feel uncomfortable taking on activities generally associated with the opposite sex. A man may feel uncomfortable doing domestic chores and a woman may feel she has failed if she requires assistance.

A woman may learn about her role function from her role complement — the infant. As in any role, an individual is dependent on feedback to determine the effectiveness of his or her behavior; thus the new mother looks to her infant's responses to her to evaluate her performance as a mother. For example, if she is capable of soothing a fretful infant she sees herself as competent; if she cannot and then someone else can, she may perceive herself to be inadequate.

#### Hard work

Certain developmental tasks have been identified for the postpartum woman.<sup>3</sup> She must accomplish the task of physical restoration, she must learn to meet the physical needs of her infant which involves a host of new skills, and she must establish an emotionally healthy mother-infant relationship.

It has been said that the woman's need to mother is relative while the infant's need to be mothered is absolute.<sup>4</sup> In order to meet these absolute needs the new mother must perceive her rela-

tionship with her baby as satisfying to each, but this may take several weeks to accomplish.

With the addition of a new baby, whether a first or subsequent infant, all the family relationships must change. In many families the responsibility for this integrative process falls on the mother; it is she who helps other family members relate to the baby and establish meaningful relationships. It is important to remember that the addition of one new family member does not increase the number of role relationships within the family group by one, rather it multiplies the number. For example, in the family of a newborn there are three functioning

## Do new parents learn beforehand?



Photo by Norris Wilson

relationships — mother-infant, father-infant, and spouse-spouse. Prior to the baby's birth, there was just one, spouse-spouse.

Another developmental task with which the postpartum woman must deal is the sense of loss. This may seem rather odd since with the birth there has been an addition rather than a loss but the disappearance of the state of pregnancy may be distressing. Some women take pride in the obvious physical changes, and they enjoy the special activities and the attention they receive. After delivery the special status of pregnancy is lost and suddenly the woman is a mother rather than a mother-to-be. There are significant changes in body image to contend with too: getting "back to normal" takes time and effort. The postpartum woman is best described as appearing five months pregnant, which may seem to be neither pregnant nor unpregnant.

Further, the woman who chooses to be a full-time mother loses the social definition she had prior to the birth of her child; depending on how she perceives the mother role she may have a sense of being devalued.

The reality of these developmental tasks is that they take time to accomplish, and many parents and nurses are unaware of both the specific tasks and of ways in which their accomplishment may be helped or hindered.

#### Behavior postpartum

An important part of the postpartum experience that must be understood is the fact that certain behaviors appear in the new mother, whether she is multiparous or primiparous. There are three phases which may be designated as the 'taking-in' phase, the 'taking-on' or 'taking-hold' phase, and the 'bursting out'.<sup>5,6</sup>

The *taking-in* phase occurs in the first few days of the puerperium and is the woman's response to the expenditure of energy during labor and delivery. In short it is a period of hunger: hunger for sleep, for food, for bodily comfort, and for talking about the experience. The woman is concerned about regaining control of her bodily functions, such as voiding. She is concerned too that she performed well during labor, that she was a "good patient". In effect, the new mother in this phase herself needs mothering. She seeks reassurance from her significant others, family and friends, that they will accept the new infant into their social systems, thereby validating her ability to produce a new member who is valuable.

Do we as care-givers, mother the mother? Do we respond to her needs, especially the need to talk about the experience? Do we assist her in physical restoration? Do we assume the immediate caretaking responsibilities for the new infant? Do we facilitate acceptance of the new infant by her family? How?

The second phase of the postpartum period has been called the *taking-on* phase and it is signalled by the woman's feeling of comfort dealing with her own body and by her interest in learning to care for the baby. Now she needs positive reinforcement that she is performing capably, and she needs feedback from both nurses and her infant. This last is an important point for the nurse to remember as often we are tempted to take over some activities from the mother, especially when she is not adept; it seems quicker and easier to do things ourselves rather than to take the time assisting the mother. I experienced a vivid example of this a few years ago: a woman had had her second baby after an interval of ten years. She had been



unsuccessful in breastfeeding with the first but she very much wanted to breastfeed this infant even though she was unsure of her ability. The infant was brought to her to nurse but was sleepy and did not feed well. A well-meaning nurse came into the room and after hearing the mother's apology that she hadn't been able to get the baby to wake up to nurse, the nurse said, "Oh, he'll wake up for me — give him to me," and she took the baby back to the nursery. The mother began to cry, and decided not to continue breastfeeding.

Although the mother is gaining more control at this time, the taking on phase is characterized by the familiar postpartum depression or "baby blues". Traditionally this has been ascribed to the massive physiological changes which occur after delivery but we now recognize another major factor involved, that of the mother's sudden awareness of the enormous responsibility of motherhood, the reality that for 24 hours a day, seven days a week, for the next many weeks and years to come she will have the responsibility of this infant. Contributing to these feelings of depression is her perception of the shift of attention from her to the baby; often the new mother is greeted with questions about the infant's well-being rather than hers, and visitors may rush off to the nursery to see the infant.

In view of the move to early discharge of the postpartum patient, understanding these two phases is especially important, for the mother going home after one or two days may be still in the taking on phase when she is sent home and told to rest and enjoy her baby — hollow words to the mother for whom reality is an unhealed episiotomy, sore breasts, unestablished lactation, and whose baby has an erratic feeding pattern and an unhealed circumcision. She is going home without too much in the way of realistic knowledge or support from community services.

The third phase of the postpartum period has been identified as that of the "bursting out-binding in" phase and has been found to occur a few weeks after delivery. In this stage, after the woman has recovered physiologically and psychologically from the delivery, she experiences a healthy revolt against the feeling of depression, isolation and lack of self-identity. She may go out with a friend, or have an extravagant evening with her spouse, but in any case she "bursts out" from under the demands of infant care. The important thing is that she feels comfortable leaving the baby in the care of another person; however, she does experience a slight degree of guilt but this concern for the baby serves only to reinforce her maternal feelings.

**Health care services—what's the reality?** One recent study<sup>7</sup> identified the major concerns of new mothers following discharge from hospital: the women had concerns about infant feeding, their own physiological state re: diet, exercise and regaining their figure, and they had problems with fatigue, emotional tension, feelings of isolation, family relationships with siblings of the infant, and with their spouses. It was found that the peak period for concerns was in the first few weeks postpartum when the women sought support and advice primarily from spouses. *None of the women identified the nurse as a potential source of support, counseling and advice.*

## Patients are not getting the care they really need



The implications are quite clear: patients are not getting the care they really need. Postpartum teaching in hospital needs improvement to incorporate more anticipatory teaching and realistic counseling for the needs of the new mother after discharge. More information must be provided about the resources available, and more services must be developed, implemented and evaluated.

Another study looking at patterns of nurse-patient interaction on a postpartum unit made several interesting discoveries:<sup>8</sup> mothers tended to obtain more information from other mothers, either by talking to them or by observing, than they did from the nursing staff. Information from nurses was generally time and task-specific — "Have you had your Sitz bath yet this morning? You need to have it twice a day, you know," — and was often repeated by other nurses without anyone ascertaining the woman's real need for information. Most nurse-patient interaction was on a one-to-one basis, rather than in a small

group. Again, the implication is clear: advantage is not being taken of the opportunity to teach a small group of mothers informally where each could benefit from the others' experience.

### Special cases

There are certain instances wherein the postpartum woman deserves special attention, the first of which is the woman who has undergone a delivery by Caesarean section. Too often the focus of nursing care in this case is on the patient as being post-operative rather than on the patient who is both post-operative and postpartum. The reality is that she, as a result of the surgical procedure, may move more slowly through the various adaptation phases than will other women. Nurses must realize too that while they may not place any sort of negative connotation on the Caesarean, the patient herself might. The following excerpt from a recent study reveals one patient's feelings about her Caesarean:

Other mothers express outright pity, and subtle and outright implications of abnormality. You feel left out, as well. You have to learn to respond to this and it can be difficult to do. If you let it, it can get you down. One woman was so condescending to me she said "Couldn't take it, I guess." The operating room recurred in my dreams regularly for two months...The dreams brought back the fears and feelings of that night, and reliving of the immediate time before, and the actual emergency treatment. Perhaps they reminded me of my own mortality. The dreams come less often as time passes. They are just not as frightening; I am not left with the same internal shaky feeling. I feel guilty about my initial reaction to my son. It was so opposite from the reaction I expected. I looked at him and felt almost nothing. I had a hard time feeling he was even mine. I remember telling my husband, "How do I know that's my baby?"<sup>9</sup>

The second special situation is the woman who has a multiple birth; while the arrival of twins or triplets is now seldom a surprise, the new mother still has special information needs postpartum. She needs to know about feeding schedules and methods of feeding — can a woman with twins breastfeed? — how to organize her time in order to meet the needs of each baby, how much and what kind of infant equipment is needed, and how to manage "twinness".<sup>10</sup> Do nurses really meet these needs or do we overlook them and cheerfully remark on the amount of "fun" the woman is going to have when she gets home?

Multiparous patients are a third special group and yet they are often neglected since, as Mercer says succinctly,



we assume they "know the ropes".<sup>11</sup> Often at the change of shift, staff report that a particular patient is "a multip and okay". Sound familiar? It is true that the multiparous woman knows the ropes having experienced firsthand the difficulties of motherhood but it is also true that she will receive less attention this time from family and friends, and she has as many, if different, concerns. Although the love a mother feels for her children is not drawn from a finite reservoir, she might worry about the amount of time she will have to spend with her other children...will this detract from her mother-child relationships? Do we ask the multiparous mother about this, or do we send her home to work this out without suggestions, advice or support?

Other special situations which are beyond the scope of this article need to be mentioned at least — the woman who has had an unexpected outcome to pregnancy such as a baby who is ill or who has an anomaly, or the woman who has a stillbirth. The adolescent mother, too, has special needs because of the imposition of developmental tasks of adolescence over those of the postpartum period.<sup>12</sup>

One might say then that all postpartum patients are 'special cases' and that is exactly the point. Postpartum care cannot ever be routine if it is to really meet the needs of the new mother.

The new father too requires some attention from nurses; although more and more commonly men attend the prenatal classes and participate in the labor and delivery, we in the hospital do not regularly involve them in the postpartum experience.

New fathers undergo a response that has been termed 'engrossment', which is simply that they are engrossed with their new baby, seeing it as physically attractive and desiring to hold and touch it. Many describe a sense of elation and increased self-esteem.<sup>13</sup> The new mother should know about this to allay her sense of no longer being the center of attention. Providing mother with some informal or formal teaching in infant care is accepted practice but do we make an attempt to involve the fathers as well? If not, we are reinforcing the myth that infant care is chiefly a feminine role.

#### Recommendations

It has been established that what is needed during the postpartum period is better patient teaching; the wise nurse, in her assessment of her patient, decides which stage of the postpartum period that patient is in so that teaching may be directed to the special needs of that particular phase. For example, the taking in phase when a woman is primarily interested in regaining control of her bodily functions is not the time to inundate

her with the myriad aspects of infant care; she will learn better later on, when she is interested in learning.

Other recommendations for more complete postpartum care include:

- inclusion of the father in infant care teaching sessions. Are classes given at times other than the traditional morning class so that men who work during the day can attend?
- utilize small groups of women for informal teaching. Patients learn from each other as well as from nurses and we should capitalize on this.
- patients should be provided with printed information as to what to expect at home, and with lists of names and

## One might say that all postpartum patients are special cases



telephone numbers for community resource persons and services.

- obstetrical units should not be understaffed. For administrators to do so is to assume that the puerperium is routine and normal for all patients and requires a minimum of care.
- to facilitate teaching, perhaps guides could be kept either at the bedside or on the charts to avoid redundant teaching and gaps in information.
- the use of a telephone follow-up service, either by hospital nurses or by the public health nurse may be of great value.<sup>14,15</sup>

#### A century of care

Comprehensive, multidimensional care to the postpartum woman and family can be provided but it requires that nurses have a full understanding and appreciation of the components and complexities of the postpartum and that

they have a commitment to provide the necessary care. The gap between the reality and unreality of the postpartum experience must be bridged. The combined life prognosis of the newly formed postpartum family is approximately a hundred plus years...surely we can invest in that family the comprehensive care that they need. ♦

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**SOMETIMES IT TAKES MORE THAN**





**WORDS TO SOOTHE AN OSTOMATE.**



# Man versus microbe: a case for the infection control nurse

Ann Beaufoy

M. Bernadet Ratsoy

Infectious processes are not new to mankind; in fact, early hospital populations were made up primarily of persons suffering from infections of one type or another. Sometimes up to 25 per cent of all hospital admissions died of causes related to a hospital-acquired infection, making hospitals an unsafe environment for both patient and attendant.

The history of nosocomial (hospital-acquired) infections can be organized into three eras. First, from the earliest hospitals to the 1940's, a time during which there was no specific therapy for any type of infection and essentially no preventive techniques. It was in this era that aseptic technique was developed. The period between 1940 and the late '50's was the era of antibiotic therapy, marked also by the development of antibiotic resistant staphylococci. There was a remarkable reduction in streptococcal infections, but unfortunately there also developed a feeling of security which led to the relaxation of the aseptic techniques developed earlier.

Finally, since the 1950's, the importance of gram negative organisms has been recognized with the introduction of broad-spectrum antibiotics. There has been an emergence of organisms previously thought to be non-pathogenic as well as antibiotic-resistant fungi and viruses.

## The problem today

Present day populations of hospitals are becoming ever more susceptible to invasion by microorganisms, fungi and viruses for a variety of reasons.

1. Diagnostic and treatment techniques frequently disturb or disrupt the body's physiologic resistance to invading organisms. Invasive techniques are ever more dramatic; some, such as urinary catheterization, intravenous therapy and anesthesia, have become commonplace procedures. Others, such as various pressure monitoring systems and cardiovascular assessments are increasing in frequency and instrumentation has become accepted as a frequent antecedent to infection. Complex and extensive surgical techniques causing increased trauma over longer periods of operating time occur more and more frequently.

2. As the geriatric proportion of the general hospital's population increases, the percentage of debilitated patients in the hospital increases as well. These patients who are usually older and sicker than were their counterparts in previous years, are correspondingly more susceptible to infection. And, as would be expected, as techniques improve, they are more commonly being applied to the older patient.

3. Since host defences are impaired in the individual with burns, diabetes mellitus, malnutrition, renal and hepatic insufficiency and those receiving immuno-suppressive therapy, many hospitalized patients are already in a compromised position.

4. The hospital environment may expose the patient to a residue of resistant bacteria spawned by broad antibiotic usage and to which he may not have had the opportunity to establish resistance.

5. Because of increasing specialization and the expansion of

services available for diagnosis and treatment, more and more hospital employees and physicians come in contact with each patient, thereby increasing the individual's exposure to infection.

6. Maintenance of basic techniques during care may be compromised because of staffing difficulties and inadequate physical facilities, thus contributing to the spread of organisms.

7. A complacent attitude, the feeling that infections can be easily controlled with antibiotic therapy has allowed the breakdown of basic techniques, especially in aseptic technique.

8. The ever-increasing mobility of the population allows for the import of previously uncommon infectious processes in to the area.

It now seems obvious that new and better antibiotics will not provide a satisfactory solution to the problem.

## What then is the solution?

Could it be prevention and control?

Indeed that is exactly the answer.

Infection control programs have become the most important means of prevention and control of nosocomial infections.

In 1959, when the need for specific surveillance of infection incidence was recognized at Torbay Hospital, England, the first Infection Control Nurse was appointed. Then early in the 1960's in the USA, Bertha Yanis Litsky proposed the establishment of a position at the level of assistant administrator responsible for what she called *Hospital Sanitation*, to counteract the lack of safety from infection for the hospitalized person.



Today accreditation of a hospital requires the formation of an Infection Control Committee responsible for an Infection Control Program. The Canadian Council on Hospital Accreditation recommends that membership of such a committee be made up of representatives from diverse clinical areas, other hospital

infection control to their colleagues the control program will become more effective more rapidly. Similarly, the success of an Infection Control Nurse is largely dependent on the recognition, acceptance and support of hospital administration and employees.



Photo courtesy St. Paul's Hospital, Vancouver

departments when there is a concern regarding infection control and the Infection Control Nurse. The size of the committee should be restricted to allow for effective functioning.

Obviously existence of the committee tells one nothing of the activities this committee actually does or does not undertake. For example, a committee which meets once a year is window-dressing, a committee which meets monthly is much more likely to be a working group of individuals interested in problem-solving.

The Infection Control committee may be responsible to hospital administration or to the medical staff organization of the hospital. Recommendations from the committee will be submitted either directly to hospital administration or through the medical staff organization and then to administration. However, depending on the nature of the recommendation, it may not be necessary for everyone to follow the complete route. Most of the concerns raised and most of the control program decisions are made by those charged with carrying out the program with these decisions being made within the policy framework established by the committee.

If the medical members of the committee can sell the concept of

#### The Infection Control Nurse

Since the Infection Control Program often is personified by the Infection Control Officer, nurse or nurse epidemiologist or whatever other title she/he may carry, selection of this individual is important. Leadership qualities, positive interpersonal skills, expertise in aseptic and antiseptic techniques, expertise in patient care and educational skills are all desirable characteristics. A registered nurse, preferably with a university background, would be appropriately prepared for this role. Useful preparation should probably include additional background in microbiology, knowledge of hospital epidemiology to assist in surveillance programs, an orientation of three to four weeks with an experienced Infection Control Nurse and an on-going education through conferences, workshops, seminars and Infection Control interest groups. To date in Canada, there are no preparatory courses for Infection Control Nurses as there are in the United States.

#### Duties and responsibilities

1. To establish and maintain a simple system of data collection, tabulation, analyses, interpretation and dissemination.

Questions which should be answered regarding this responsibility include "What kind of information should be collected?" "How can it be collected most easily with the greatest degree of accuracy?" and "What will be done with the collected data?"

2. To carry out surveillance through regular contact with all hospital departments, particularly those providing patient care.

Means to accomplish this responsibility include daily rounds to the nursing units, regular visits to other hospital departments, evaluation of equipment and defining procedures to be used for prevention of infections. It is very important that all hospital employees have some understanding of the functions of the Infection Control Nurse.

3. To carry out investigations of particular problems.

The specifics of such investigations will depend upon the services, such as technician time, and facilities available to any particular Infection Control Nurse. The nurse's deductive reasoning is tested in tracking down the source of an organism, such as in the case of an outbreak of Salmonella.

4. To perform an educational function for all persons using the hospital facilities.

Group teaching in orientation programs, such as new employee orientation including new interns and residents or ward inservice programs, are always appropriate and productive to some degree. We believe that individual teaching which is usually carried out in the course of problem-solving with the individual nurse is much more productive of results. The Infection Control Nurse as role model to demonstrate such things as personal

hygiene and appropriate dress is also an important function. The program can be kept at the forefront by holding "Infection Control Days" or week, circulating articles related to a specific infectious process and by using the hospital paper.

5. To carry out environmental and personnel monitoring when appropriate. This responsibility includes collection of specimens from high risk areas, or personnel, follow-up of contacts and carriers and monitoring of suspicious equipment and products.

6. To act as resource person to all persons working in the hospital.

It is imperative that all hospital personnel are aware that the Infection Control Nurse is always available but also that there are written resources



available. Every nursing unit and hospital department should have a procedure manual which contains Infection Control policies, both general and specific in nature.

7. To maintain the credibility of a control program.

8. To maintain liaison with various community agencies, such as the City Health Department, Tuberculosis Control Centre and Home Care.

9. To institute new or revised policies and procedures for Infection Control through membership on the Procedure Manual Committee and by participating in development of standards as part of the Quality Assurance Program.

The Infection Control Nurse must be knowledgeable and consistent, using problem-solving techniques so that all are aware of the logical approach used to resolve questions. The nurse must be prepared to defend the program against hostility, negativism and to accept not only ideas for improvement, but also criticism. She must not only support the nursing staff who are carrying out accepted procedures but also be willing to point out errors.

It is easy to see from this description that the job of the Infection Control Nurse is a full time position. Recommended coverage is one Infection Control Nurse for every 250 patient beds (U.S.A. standard).

### Principles of Effective Functioning

Unfortunately infection control is an emotionally charged area of function. Many persons resent the inconveniences involved with control techniques. A nurse may say she wished she had never sent the specimen to the Laboratory, or some physicians may regard an infection as a black mark on their reputations or resent what they see as interference in their plan of therapy. Emphasis must be placed on the improvement of performance and not on the assignment of blame. Every Infection Control Nurse's function is based upon sound knowledge of policies set by the Infection Control Committee and upon a set of principles. Following are the principles which we have found most useful:

1. Because of the difficult situations in which she will become involved, the Infection Control Nurse must know she has administrative backing and medical consultation when necessary.
2. The Infection Control Nurse in turn must be supportive of nursing staff who carry out control procedures particularly in the face of antagonism.
3. Nurses have the authority and responsibility to submit specimens to

the Laboratory if infection is suspected.

4. Isolation of patients is an administrative action designed to protect staff and other patients. It is not medical treatment.

5. Nurses have the authority and responsibility to initiate control techniques on the basis of laboratory and clinical evidence.

6. Failure to apply knowledge already possessed regarding infection control underlies a large proportion of nosocomial infection.

7. An infection control program is only as good as the desire of all hospital personnel to prevent infections.

8. Establishing the importance of infection control results in more accurate and complete record keeping, more consistent attempts at maintaining basic technique and quicker responses to the need for institution of control procedures such as isolation.

9. Always use a reasonable and practical approach. No procedure is without loopholes but that is no reason not to undertake control measures. These measures occasionally require adaptation related to the individual patient care needs.

10. Never expect anyone to remember a procedure. Provide complete, easily interpreted instructions in writing for every department and nursing unit.

11. Infection control methods must be easily implemented to encourage compliance.

12. Constant repetition of well-known principles of control is necessary. Every encounter is an educative opportunity to apply problem-solving to an infection control problem.

13. Concentrate on the single most important control procedure — handwashing.

14. Constant, gentle surveillance promotes willing cooperation among staff members.

15. The Infection Control Nurse must be available for reinforcement, for information, etc. Frequent rounds will demonstrate availability and establish credibility.

16. Even the best program loses momentum over the years. Sometimes a change is indicated simply because the old program no longer has appeal and no longer stimulates the necessary interest. ♡

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# Hepatitis B an occupational risk

Jean Keck and Peggy Swerhun

J.W., a 25-year-old male, was first seen in the Employee Health Department at the time of his pre-employment medical assessment. The only significant finding in his medical history was a contact with hepatitis B two months earlier at another hospital. He had no medical complaints and no abnormalities were noted on physical examination. Routine blood work including HBsAg (Australian antigen), HBsAb (Australian antigen antibody) and SGOT were taken. The results revealed serum positive for HBsAg, negative for HBsAb and an SGOT of 78 IU/l (normal 8-30 IU/l). His serum had been negative for HBsAg and HbsAb in 1975 and 1977.

When these abnormal results were discovered he was seen by the Employee Health physician and instructed to rest at home and return in one week. Following a week's rest at home he reported fatigue and intermittent dark brown urine which had, in fact, been present for three weeks. He had no fever or malaise, no light colored stools, no jaundice and appeared well. On examination there was no hepatomegaly. At this time his total bilirubin was 0.4 mg/dl (normal < 1.00), direct bilirubin 0.1 mg/dl (normal < 0.5), alkaline phosphatase 157 IU/l (normal is 56.0-244), SGOT 184 IU/l, SGPT 291 IU/l (normal is 6-30) and GGPT 74 IU/l (normal is 11-51).

He continued to rest at home for a period of 4 weeks returning weekly for assessment and repeat liver function tests. During this time his liver function tests showed gradual improvement and it was decided that he could return to work. His direct bilirubin at this time was 0.1 mg/dl, alkaline phosphatase 137 IU/l, SGOT 107 IU/l, SGPT 200 IU/l, and GGTP 76.5 IU/l. His serum remained positive for HBsAg.

At this time he was seen by the Employee Health physician and nurse. Instructions were given to him by the Infection Control Nurse on precautionary measures to be taken while on duty. He was restricted from serving meals to patients and performing vena puncture and other treatments. Liver function tests were repeated weekly for several weeks but remained abnormal and showed little improvement, his serum remained positive for HBsAg. He seemed tired but was able to carry out his duties.

Despite the restrictions he had been given on his return to work, J.W. attended a Cardiopulmonary Resuscitation Course (C.P.R.) which involved practicing mouth-to-mouth resuscitation on a plastic manikin.

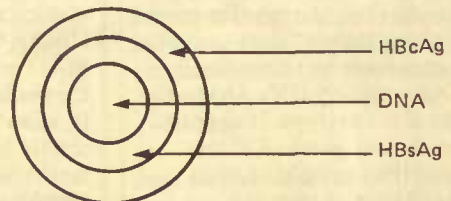
significant contact with Hepatitis B in the previous three months. Fortunately all baseline and three month blood samples were negative.

## Hepatitis B

Hepatitis B is a systemic viral infection which predominantly affects the liver. Transmitted by direct contact with blood products, this infection is known more commonly as "serum hepatitis". Other types of viral hepatitis include: hepatitis A, formerly known as "infectious hepatitis", a comparatively brief illness without a tendency to chronicity; and another form of hepatitis currently called "non-A, non-B hepatitis" which is probably transmitted by blood products and may cause chronic disease. However no specific virus has yet been identified.

Figure one:

Viral particle  
found in hepatitis B  
infected serum



Although the manikin was cleansed with 70 percent isopropyl alcohol in between each practice session, it was impossible to cleanse it during instruction with the two man rescue procedure. Thus, nine other staff members taking the same course had direct contact with J.W.'s saliva. When a sample of his saliva was obtained and sent for HBsAg determination, the report returned positive for HBsAg. The Employee Health Nurse drew up a contact list of the staff involved, interviewed them and obtained baseline blood samples for HBsAg and HBsAb. The results revealed that none of these staff had had any

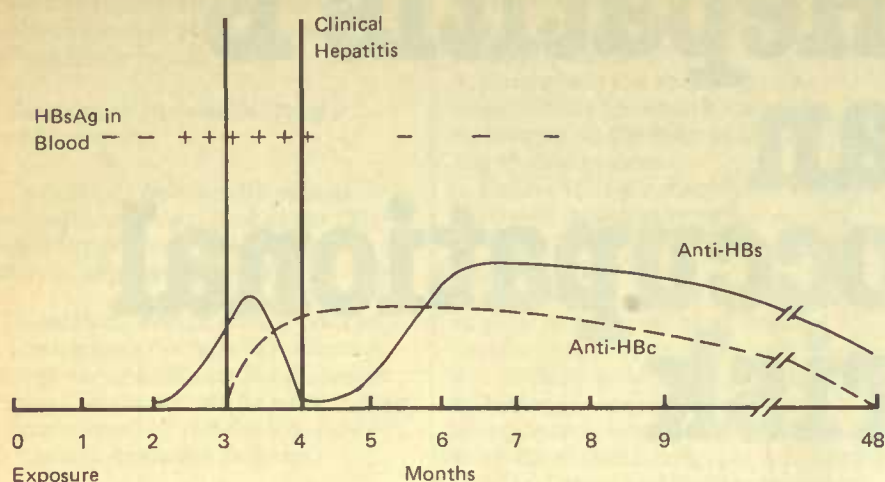
## Diagnosis

Diagnosis of hepatitis B became easier when a specific serum antigen associated with the infection was discovered. Dr. B.S. Blumberg identified this antigen in an Australian aborigine in 1965 and in 1976 received the Nobel Prize in medicine for this discovery. Later it was shown that the antigen initially called the "Australia Antigen" was associated with hepatitis B, and now it is called the hepatitis B surface antigen (HBsAg).

When serum from patients with hepatitis B is studied with an electron microscope, viral particles can be seen.



Figure two: Acute viral hepatitis type B



One particle, the Dane particle, is now thought to be the hepatitis B virus. It has an inner core surrounded by an envelope. The core is associated with the hepatitis B core antigen (HBcAg) and the outer coat contains HBsAg. Small spherical particles and tubular particles are also present: these are considered to be excess coat protein (See figure one).

The incubation period of hepatitis B may extend from six weeks to three months. Some individuals, possibly the majority of persons infected, never develop clinical illness. HBsAg may be found in the blood for a period of time following the acute stage of illness; if it is detectable for more than four months following the acute state of the disease, chronic hepatitis B should be considered. In most cases following acute infection, antibodies known as anti-HBs or HBsAb, can be detected. These antibodies may remain for several years thus providing complete or partial immunity to subsequent hepatitis B infection. An antibody (HBcAb) to the core antigen also develops. It appears early in the clinical phase of illness whereas anti-HBs does not become apparent until later, during the convalescent stage. Sometimes HBcAb is the only clue to hepatitis B infection (See figure two).

The symptoms of hepatitis B vary with the individual. Nausea, vomiting, fatigue, malaise, skin rash, loss of weight and headaches may precede the onset of jaundice by one to two weeks. Clay colored stools and dark amber urine may be noticed one to five days before jaundice appears. With the onset of jaundice, some of the constitutional symptoms will diminish. There will then be a mild weight loss of two to five kilograms which may continue throughout the entire icteric

phase, the liver may become enlarged and tender, the individual may experience upper right quadrant pain, and splenomegaly may be present in 10 to 20 percent of individuals. The duration of the post icteric phase is variable ranging from two to 12 weeks. In three quarters of the uncomplicated cases, complete clinical and biochemical recovery can be expected three to four months after the onset of jaundice.

Diagnosis begins with a thorough medical history including a drug history as some drugs produce a picture similar to that of acute hepatitis. Acute hepatitis B may also be confused with cholecystitis, common duct stones or ascending cholangitis, because of their symptoms of nausea, vomiting, right upper quadrant pain and fever. In the elderly it may be confused with cancer of the pancreas or obstructive jaundice due to stones in the common bile duct.

Laboratory tests are necessary for making a diagnosis and should include HBsAg, HBsAb and liver function tests. SGOT and SGPT levels increase during the acute viral stage and precede the rise in bilirubin level. Liver function tests should be checked every one to four weeks until normal and HBsAg and HBsAb in four to 12 months after the acute stage has subsided. Viral diseases such as infectious mononucleosis, herpes simplex and toxoplasmosis all share certain clinical features with viral hepatitis, that is, they cause an elevation in serum SGOT and SGPT.

#### Transmission

Material from both carriers and individuals with acute hepatitis has been subject to intense scrutiny as to its ability to transmit the virus. The following levels of HBsAg have been found:

- blood — high concentrations.
- urine — may be present in minute amounts in the urine in the acute phase

and in carriers with normal renal functions.

- feces — early serological tests on fecal extracts from individuals with acute hepatitis gave false-positive results.
- saliva — often detected in the saliva of patients with acute diseases. It is only of academic importance to discuss whether the antigen is actually secreted by the parotid gland or arises from contamination of the specimen with blood in the mouth, since it is known that hepatitis B is transmissible by a bite from a carrier.
- menstrual blood — contains concentrations comparable to those in the circulation.
- semen — has been detected in semen of patients with acute illness.
- milk — has been found in both colostrum and milk.
- sweat — has been found to be present in sweat of carriers.
- cerebrospinal fluid — absent.

Sporadic outbreaks of acute viral hepatitis B have been reported in blood bank employees, nurses, lab technicians, doctors and dentists. Exposure to this virus may result from contact with blood or other body fluids, when starting or maintaining intravenous cannulas, drawing blood, changing surgical dressings, caring for catheters, handling surgical instruments or using defective gloves during surgical procedures. In some instances contact with heavily contaminated articles is sufficient. Hepatitis B is definitely an occupational hazard amongst health workers with laboratory workers, general surgeons, dentists and staff in renal units seeming to be most at risk.

#### Carriers

HBsAg is carried in the serum of a percentage of the general population. Many of these carriers may be completely asymptomatic and in excellent health while others may suffer from significant liver disease. For some unknown reason, the carrier rate is higher among men than among women.

One theory on the development of carriers is that these individuals have a persistent infection following a subclinical illness of hepatitis B. Environmental factors may also play a role in determining whether or not a person becomes a carrier. Repeated exposure to hepatitis B increases the risk of becoming a carrier, whether through transfusions or through occupational, household or sexual contacts. A high incidence of hepatitis B has also been observed in the male homosexual population, patients with a past history of hepatitis, multiple transfusions and parenteral drug abuse. Approximately 10 percent of individuals with acute hepatitis B became chronic carriers of HBsAg. One



theory or possible cause of this is an inadequate production of Anti-HBs to terminate the infection. Therapeutic immunosuppression and certain diseases such as chronic liver disease, chronic renal failure, leukemia, Hodgkin's Disease, Down's Syndrome and leprosy may also increase chance of carriage with the duration varying.

#### Isolation procedure

All patients with positive HBsAg serum must be placed on enteric isolation. The importance of hand washing in prevention of the transmission of hepatitis must be stressed, not only for hospital personnel, but also for the patient and all contacts. This isolation procedure involves the following steps.

1. Explain the procedure to the patient.
2. A single room must be used with separate washroom facilities.
3. Gowns must be worn by persons having direct contact with the patient.
4. Masks are generally not necessary, but must be worn by the patient when using the telephone.
5. Disposable dishes must be used.
6. Disposable gloves must be worn when performing veni-punctures; a vacutainer holder and tourniquet should be kept in the patient's room.
7. Patients should be instructed to wash their hands thoroughly before and after meals, after using the washroom and before leaving the room.
8. All linen and garbage must be double-bagged and removed immediately.
9. Special precautions must be taken with the following:

- Needles must be inserted into their original plastic sheath before discarding (special disposal container must be provided).
- Extra care must be taken to avoid needle pricks.
- Disposable syringes must be discarded into special containers.

10. Laboratory Specimens — urine, sputum, stool and blood — must be obtained in the patient's room. Containers must have a tight fitting lid. All samples must be double-bagged and labelled **ISOLATION: HEPATITIS**.

11. Instruct and caution medical and nursing personnel to take special precautions to prevent spread of infection when patients undergo surgical or obstetrical procedures.

Inservice education programs should provide necessary information and training techniques for all personnel working in high risk areas. Written procedures should be available for the following personnel: nursing, physicians, laboratory, housekeeping and non-medical personnel.

#### Instructions on discharge from hospital

1. Instruct the patient and provide the

patient's family with written information on precautionary measures to be followed.

2. Inform the patient that he must not donate blood.
3. Advise the patient to report positive test levels of HBsAg to his dentist so that appropriate precautions can be taken when he is being treated.
4. Instruct the patient on the importance of medical follow-up.

#### Immunization

The use of gammaglobulin in the prevention of hepatitis B is controversial. Immune serum globulin has been found to be effective in providing protection against hepatitis A but this has not proven to be the case with hepatitis B. Specific immune globulin called hyper-immune-globulin (HIG) containing a high titre of anti-HB<sub>s</sub> has been used experimentally in preventing hepatitis B, but is not in general use in Canada at this time and some people fear that a high proportion of carriers might arise from widespread use of this serum. Active immunization for hepatitis B is being developed but has not been approved for use at this time.

#### Recommendations for C.P.R. training

1. All staff must have blood taken for HBsAg and HBsAb within a 3-month period prior to taking a C.P.R. course. The results must be obtained before the staff member can participate in the course.
2. A history should be taken by the Employee Health Nurse to determine the presence of any physical, acute or chronic medical conditions.
3. Staff may not participate in C.P.R. if they are found to have any of the following infectious conditions:
  - blood positive for HBsAg
  - upper respiratory infection
  - Herpes Simplex (cold sore)
  - dermatologic lesions.
4. A plastic face protector should be used on the manikin to prevent cross infection.
5. The manikin must be washed thoroughly after each session and course instructors made responsible for proper cleaning and maintenance of manikins. The manikin head should be disassembled and washed with soap and water plus 0.5 percent sodium hypochloride (Hygeol) solution (0.5 percent sodium hypochloride to nine parts water). *Note: Isopropyl alcohol 70 percent is not effective against hepatitis B virus.*
6. Manikins should be inspected routinely for signs of physical deterioration, such as cracks or tears in plastic surfaces.
7. Inservice education for course instructors is essential in preventing cross infection. ♦

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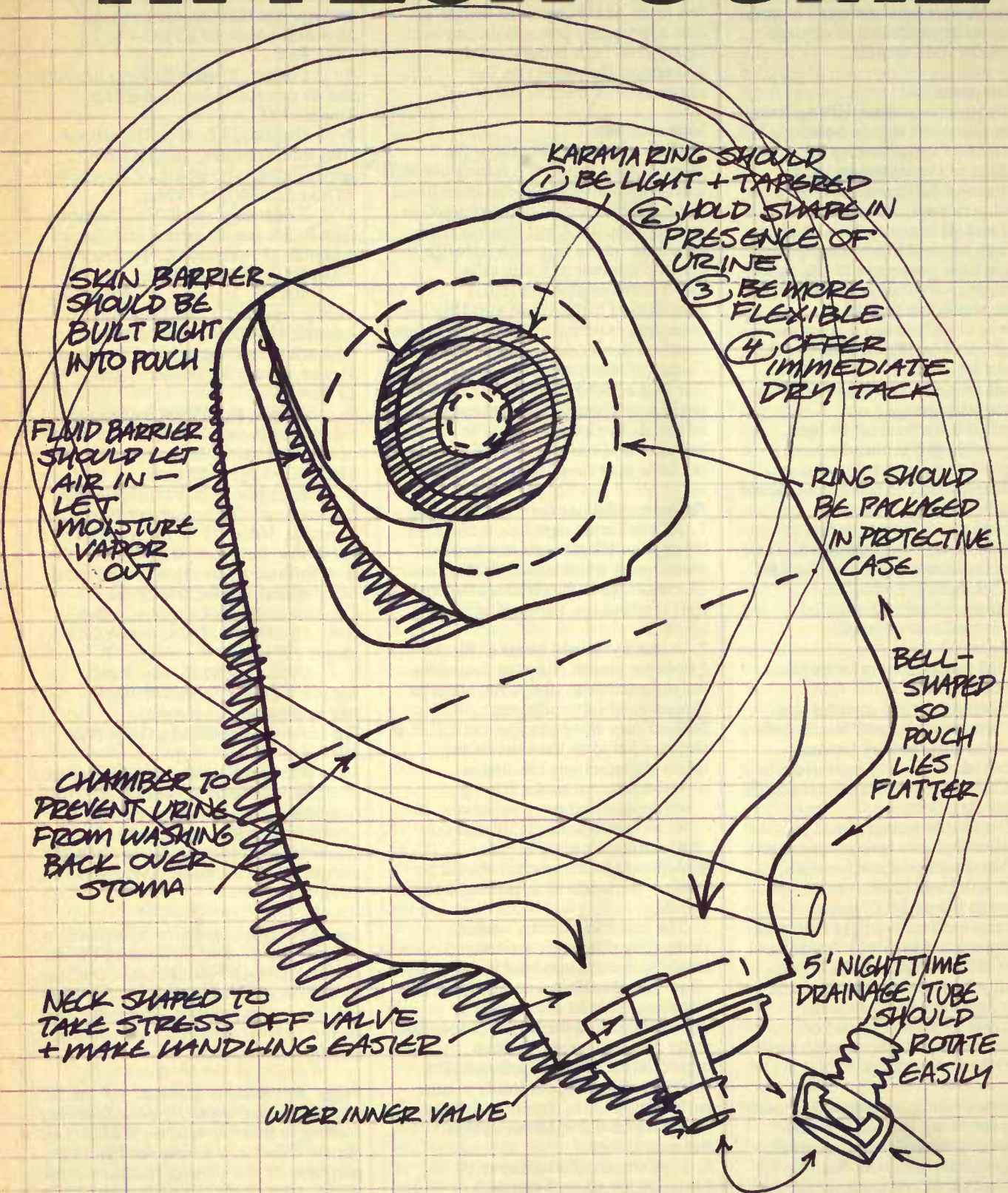
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**Acknowledgement:** The writers would like to thank Dr. Eve A. Roberts for her assistance in reviewing this paper.



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Breast cancer is currently the most common type of cancer (apart from skin cancer) found in women.\* Each year, close to 8,000 women in Canada are diagnosed as suffering from this disease. Breast lumps, therefore, though common, are a source of much stress. The majority of breast lumps, however, are not cancerous but represent benign breast disease (BBD). The participants in this study, nursing students at Vancouver General Hospital at the time of the original interview and physical examination, were contacted up to 34 years later and asked to identify breast problems and factors that might be related to these problems. Using this information, the authors assess the frequency of BBD and identify some of the factors that may predispose or tend to prevent its occurrence.

## Breast disease in nurses, a 30-year study

J. Mark Elwood, M.D. T.G. Hislop, M.D.

### The study

In 1945, and from 1947 to 1956, all second year nursing students at the Vancouver General Hospital were informed of this study: a total of 1,374 of them participated. At entry each participant had a physical examination and completed a questionnaire covering her personal and family history. While many nurses kept in contact with the study group, no deliberate follow-up effort was made until 1979 when, using nursing registries, class secretaries, notices in nursing journals, and radio messages, we attempted to contact the original participants and succeeded in identifying 787 of them. We sent each one a questionnaire asking about breast problems and factors that might be related to such problems and received 726 replies, 94 percent of located nurses, an extremely high response rate. The questionnaires were generally completed with considerable care, and many nurses provided us with further information, or took the trouble to check back to their physician or other family members in order to give the correct response to some questions. We were able to compare the nurses whom we had located with those whom we had failed to locate in terms of their original questionnaires and physical examination results at study entry, and there were no important differences between the two groups. We believe, therefore, that the women we did contact are representative of the entire group.

Our study examined both symptomatic and biopsied BBD. Symptomatic BBD includes a history of breast lumps or cysts, whether or not biopsied; biopsied BBD includes diagnoses of fibrocystic disease, fibroadenoma and intraductal papilloma.

### Incidence of breast disease

Two percent (17) of the 726 respondents reported having had breast cancer; thirty percent (215) reported a history of symptomatic BBD. One-half (107) of

these women with symptomatic disease had biopsy confirmed BBD. As we expected, the proportion of women who had developed symptomatic BBD rose with age, increasing from three percent at age 20 years to over 30 percent by age 50 years (See table one).

Likewise, the probability of having had a biopsy for BBD increased from less than one percent at age 20 years to 17 percent by age 50 years. However, the rise with age was not regular: the chance of developing either symptomatic or biopsied BBD at a particular age (the age specific incidence rate) showed a distinct peak at age 20 to 24 years followed by a decline and then a rise to age 50 years. This suggests that at least two distinct types of BBD exist that can be separated, at least in part, by age. A review of available pathology reports showed that fibrocystic disease and fibroadenoma were both frequently diagnosed before age 30 years, whereas only fibrocystic disease was frequently diagnosed after that age.

Risk factors (characteristics associated with the development of BBD) were analysed separately for symptomatic BBD and biopsied BBD; in general, the trends in risk were similar. Because of the bimodal age pattern in BBD incidence, we assessed these factors for biopsied BBD before and after age 30 years separately. These findings are now discussed as they relate to recognized risk factors for breast cancer as reviewed by Kelsey<sup>6</sup> (See table two).

### BBD and breast cancer — similarities and differences

A higher incidence of biopsied BBD was found in women who:

- had not had children
- had had an abortion
- had a sister with breast cancer
- had reported frequent premenstrual breast engorgement and pain, or
- had irregular menstrual cycles.

Nulliparity and a family history of breast cancer are both recognized as related to a higher risk of breast cancer. Premenstrual breast engorgement or pain, and irregular menstrual cycles have

been associated with an increased risk of breast cancer in several studies, but the association is not, as yet, conclusive. Many studies have now shown conclusively that when age at first delivery is taken into account women who have breast fed have the same risk of breast cancer as those who have not.<sup>6</sup> Similarly, breast feeding did not change the risk of BBD in our study group.

We found that women who had used oral contraceptives, who had a heavier body build as assessed by a weight to height ratio, and who had larger breasts as assessed by physician examination or brassiere size, reported biopsied BBD less frequently than women without these characteristics. In contrast, breast cancer is known to be more common in relatively obese women, whereas no association has been reported with oral contraceptive usage or breast size. We found no association between the occurrence of BBD and age at first delivery, ages at menarche and menopause or type of menopause, all of which are known to alter the incidence of breast cancer. Women who had had abortions reported BBD more frequently; no such association has been confirmed for breast cancer. We could not distinguish the type of abortions; most would have been spontaneous.

### Discussion

Very few studies have attempted to measure the incidence of BBD but our finding that it had affected at least 30 percent of the nurses in our study by the time they were 50-years-old is consistent with other investigations.<sup>7-9</sup> BBD is a very common disease but, in addition to its prevalence, it is also important because of its association with breast cancer. Women with fibrocystic disease are two to four times more likely to develop breast cancer,<sup>1-5</sup> a risk that persists for at least 30 years after diagnosis of fibrocystic disease.<sup>1</sup> The association of fibroadenoma with breast cancer is less clear.<sup>2,5</sup> Recent pathological studies suggest that the increased risk is only related to certain types of benign disease, with other types carrying no breast cancer risk.<sup>4,5</sup>

\*The number of cases of lung cancer is rising rapidly and may soon overtake that of breast cancer.



**TABLE ONE: FREQUENCY OF BENIGN BREAST DISEASE BY AGE**

Percentage of nurses in the study who, by the age shown

Age	had had a biopsy for benign disease	had had symptomatic BBD without a biopsy	had not reported any BBD
	%	%	%
18 (study entry)	1	1	98
20	1	2	97
25	4	3	93
30	5	5	90
35	7	6	87
40	10	8	82
45	14	11	75
50 (end of follow-up)	17	14	69

Note: The percentages shown are cumulative, e.g. of nurses aged 30, 5 percent had had a biopsy. The percentage of women with new findings is given by subtraction — e.g. between age 30 and age 35, 2 percent of nurses (7 percent - 5 percent) underwent their first biopsy.

Most women who develop BBD will not develop breast cancer even though BBD and breast cancer are, to some extent, related. Our study, like some others,<sup>7,10,11</sup> has shown that, while a few factors seem to be related to an increased incidence of both benign disease and breast cancer, other factors appear to have differing effects for the two diseases, reflecting a difference in causative factors.

Our study findings are consistent with the hypothesis that BBD is due to a relative excess of estrogen resulting from an endocrine imbalance. (Estrogen stimulates proliferation of epithelial cells and ductal growth in the breast, while progesterone promotes the development of acini.) The major risk factors we have identified, such as premenstrual breast discomfort and irregular menstrual cycles are known to be related to relative es-

trogen excess, while nulliparity and the occurrence of spontaneous abortions could also be related to such a mechanism. The factors of age at first delivery, age at menarche, and age at menopause are also thought to depend for their relationship with breast cancer occurrence on a hormonal mechanism, but the mechanism must be different from that involved in the causation of BBD, as these factors are not related to BBD risk.

One of the most intriguing contrasts is the increased incidence of breast cancer relative to weight (higher in more obese women) compared to the decreased incidence of BBD. It has been suggested that the lower risk of BBD might relate only to greater difficulty in diagnosing a breast lump in a woman with a larger breast, but our study shows that the relationship with general body build persists even within women of similar

breast size. These and other issues in this study are discussed more fully elsewhere.<sup>12</sup>

One question yet to be answered is why only approximately half of all women who develop symptomatic BBD undergo a biopsy, and what are the determining factors leading to a biopsy. Our study did not show any marked difference in terms of personal characteristics and past medical history between those who were biopsied and those who were not.

The wholehearted enthusiasm of nurses involved in this study has encouraged us to look further at this question, and we are undertaking a second study looking more particularly at the way lumps are recognized, and the response made to them by the woman and by her physician. With their specialized training and interest in health matters, nurses provide an ideal group for such a study.

**Acknowledgement:** *We wish to thank all the nurses who participated in this study over the years and Dr. D.A. Boyes and the other members of the staff at the Cancer Control Agency of British Columbia for their interest, helpful comments and participation. We are grateful to the Canadian Cancer Society, British Columbia and Yukon Division, for encouragement and financial support; to Karen Anderson for typing and to Candace Elwood, RN, for reviewing the manuscript.*

*Breast disease in nurses, a 30-year study* is based on a more extensive report, "Risk factors for benign breast disease: a 30-year cohort study", scheduled to appear in the February 1, 1981 issue of the Canadian Medical Association Journal. (for references see page 41)

**TABLE TWO: CHARACTERISTICS PREDISPOSING TO BENIGN BREAST DISEASE AND TO BREAST CANCER**

Characteristic	Effect on BBD risk	Effect on breast cancer risk
Nulliparity	increase, after age 30	increase*
Breast cancer in sister	increase, after age 30	increase**
Premenstrual breast engorgement	increase, before age 30	uncertain
Premenstrual breast pain	increase, all ages	uncertain
Irregular menstrual cycles	increase, before age 30	uncertain
Previous abortion	increase, before age 30	no effect
Use of oral contraceptives	decrease, after age 30	no effect
Heavier body build	decrease, after age 30	increase
Larger breast size	decrease, before age 30	uncertain
Late age at first delivery	no effect	increase*
Early age at menarche	no effect	increase
Late age at menopause	no effect	increase
Artificial menopause	no effect	decrease
Breast feeding	no effect	no effect

\*Breast cancer risk rises with later age at first delivery, and at first delivery after age 30 appears to confer a higher risk than is seen in nulliparous women. An increase is also seen with breast cancer in mothers and other close relatives.



Home Care, a provincially administered and financed program, combines the services of a range of community health care professionals to form a team working toward the common goals of the patient. Patients can receive needed rehabilitative or palliative care in a familiar environment. For the nurse, Home Care can also be a rewarding and gratifying experience.

# Shirley, a success story

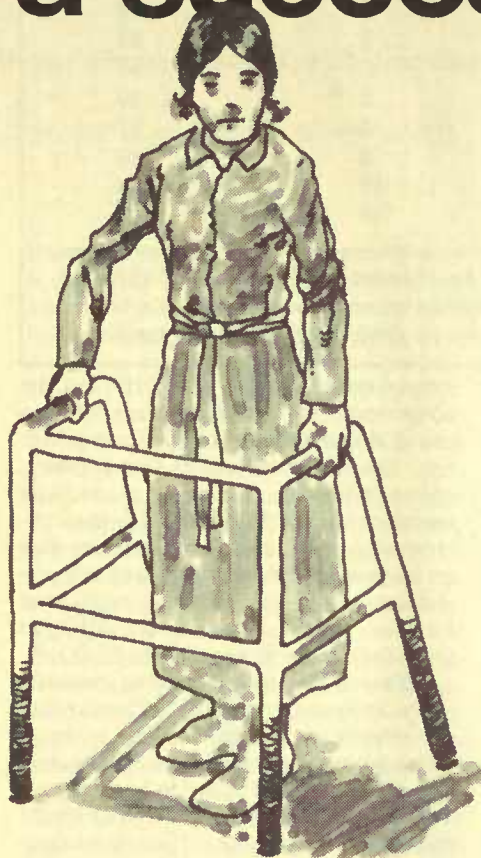
*Noreen McNairn*

Shirley Sims was diagnosed as having Parkinson's Disease at the age of 27, but, for the next nineteen years, she seldom sought medical supervision. During this time, she gave birth to six children — all girls. Now, at forty-eight, she was walking with a walker and was both unwilling and unable to do much for herself or her family. Separated nine years earlier, she was living in a small downtown apartment with her youngest daughter, aged thirteen.

It was on a June morning three years ago that Shirley slowly shuffled into Dr. Foster's office, her hair dishevelled, rumped dress loose on her wasted frame, shoes untied and no stockings. Eyes fixed on the floor, she answered his medical queries in a weak whisper. Dr. Foster realized that she was in need of both emotional and physical support if she was to remain at home but even he couldn't possibly have foreseen the amount of frustration and team effort on the part of health professionals, homemakers and family that would ensue over the coming year.

The next day, Shirley was referred to our Home Care program. As coordinator, I began to assemble her file. Although her somewhat unusual and scant history made it difficult to establish a data base, I went to work on her case. After discussions with Dr. Foster, I began to delineate Shirley's needs and the personnel that would be necessary to assist her. Our goal was to help her attain a maximum level of functional independence within the limitations of her disease.

Initially, I asked the VON to send a nurse to help with general care and to assess the need for other services such as meals-on-wheels or homemaking. Monitoring nutrition, medications, vital signs and the family situation would give us a better idea of how her care plan would evolve. However, when I heard the VON report the next day, I knew we needed additional help. The nurse had found the apartment in an incredible state of disarray and neither mother nor daughter was capable of caring for herself. I immediately asked the Visiting Homemakers Association for



help. They could take care of the initial tidying up of the apartment and then work with Shirley and her daughter to increase their motivation to do more for themselves.

As time went on, it was obvious that working with the Sims family was by no means an easy task. Their youngest daughter, Donna, had never been given any responsibility for either herself or for the household. As a result, she had accepted her older sisters' label of a "lazy, useless teenager". She isolated herself both physically and emotionally from any decision-making or cooperative activities. Forcing a confrontation would be unwise, so we alternated homemakers to minimize the frustration to any one individual. Shopping and laundry were done by the older daughter who lived in an adjoining apartment so the homemaker made meals, washed dishes and did the vacuuming — hardly a rewarding situation from her point of view.

For two months, the nursing care plan covered the bare necessities. Shirley showed little motivation to take care of her own personal hygiene, so the nurses helped her bathe, shampooed her unruly hair and encouraged a more

balanced diet. Despite her attitude, Shirley wanted to stay at home and Home Care was willing to support her even though staff frustrations were mounting.

By the end of August, Shirley's physical condition had worsened. She was admitted to hospital suffering from levo-dopa toxicity. The prescribed levo-dopa, used to overcome the depletion of dopamine that occurs in Parkinson's Disease, was replaced by bromocryptine. The results were encouraging and Shirley could return home again.

When we met to discuss her plan of care, it was obvious that Shirley had become more receptive to suggestion. The occupational therapist assigned to the case developed an intensive education program in activities of daily living.

A later meeting indicated that Shirley was responding well to this more demanding treatment plan. One specific homemaker, working with the occupational therapist and Shirley, had succeeded in having her assume a more active part in personal and household management. What had been a totally frustrating situation was gradually becoming a rewarding process of rehabilitation. The nurse was now only giving guidance in bathing since Shirley had mastered safe transfer techniques and, thanks to the occupational therapist, Shirley began to enjoy carrying out simple household tasks. The homemaker found herself assisting with household duties rather than waiting on an unmotivated patient.

After a few weeks, it became obvious that the time was right for a conference involving Shirley, Donna, two other married daughters, the VON nurse, the homemaking supervisor, occupational therapist, the family doctor and myself. This would allow us to assess and redefine the goals originally established for and with Shirley. We met in Dr. Foster's office on November 17. Shirley was no longer the shy little mouse with the rumped clothes who had come into this office six months before. She spoke out



clearly and audibly, in marked contrast to the almost unintelligible whispered tones she had used before. It was clear that a lack of confidence rather than the debility of her disease had been responsible for eroding her vocal abilities.

During the meeting, family conflicts and concerns were aired without antagonism but rather with relief. The opportunity to voice them was long overdue. The older sisters admitted that they had, without realizing it, been downgrading Donna for most of her life. They had regarded her as an unresponsive child rather than as an adolescent entering adulthood with virtually no family support. Everyone agreed that communication between them was improving and even admitted that they were beginning to feel like a family again. Donna had begun to cooperate with her mother in doing dishes and making her bed and they both took more pride in their personal appearance. It was an effective beginning that no one had envisioned so soon.

In January, 18 months after our first contact, a follow-up meeting revealed that Donna and her mother were definitely caring for and about each other. Donna's school grades had improved significantly and mother and daughter appeared much happier and

more open in their conversation. Occupational therapy had been discontinued several months earlier but the homemaker was still providing assistance. Shirley did not choose to attend a day care center that had been suggested. She did however accept weekly visits from a volunteer visitor, arranged by the VON who encouraged conversation and involved her a little more in the world outside the apartment door.

Shirley and Donna have since moved to western Canada to join other members of the family. Although we may never meet again, none of those who were caught up in the maelstrom of confusion and frustration that enveloped the Sims family will ever forget the ultimate satisfaction that was ours when we succeeded in opening the door of independence for someone imprisoned by her physical, emotional and social situation. ♡

*Noreen McNairn, PHN, BScN, is the assistant administrator of the Hamilton-Wentworth Home Care Program. In addition to her work with the VON, she has been involved in teaching programs for health professionals and for homemakers. Noreen has had several articles published on Home Care and has also given lectures on Home Care, lung disease and skin ulcers.*

## Breast disease in nurses (continued from page 39)

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Gabrielle Monaghan

The symptoms are there for anyone to see.

- One of this country's leading nurse educators, at the recent Combined Canadian American Hospital Conference in Montreal, called on administrators in the audience to become more "democratic" in their relationships with nurses on their staff.<sup>1</sup>

- One quarter of the nurse respondents in a survey conducted by RN Magazine cited "poor communication between nurses, doctors and administrators" as one of the reasons they are leaving the profession.<sup>2</sup>

- More than half (55.6 percent) of the nurses taking part in an earlier survey on job satisfaction by the same magazine recognized "no input in matters concerning you" as a crucial problem.<sup>3</sup>

- Three of the 15 resolutions approved by voting delegates at last spring's annual meeting of the CNA were aimed at increasing the education and power base of the nurse managers who direct nursing staff and speak for nursing on an administrative level.

Only an ostrich would try to deny that the relationship between the chief executive officers of many if not most Canadian hospitals and, to a lesser degree, other health care institutions and the nursing staff who work in them is a troubled and troubling one.

Reorganizing the nursing department may not solve the problem. Nor is organization theory helpful: it's quite possible to have a nursing department structured on an impeccable model but, like a Ferrari with an empty gas tank, it simply does not run.

What then is the answer? I believe that, first of all, we must come to grips with the fact that many administrators lack conceptual knowledge of the work environment in which nurses operate. What this boils down to is that, most of the time, when administrators talk about nursing and what nurses do, they are not dealing with the realities of practice in today's work setting.

Medical staff and management are supposed to get this information from the director of nursing but all too often, given the busy schedules of hospitals, the opportunity for this exchange of ideas simply does not occur. Somehow, administrators must be made to realize that nursing really is different, that nurses and other health care workers simply cannot be lumped together as "staff", employees of the institution they direct.

The uniqueness of nursing, both in terms of the work content and the workforce, cannot be over-emphasized. Alone among health care workers, nurses have responsibility for continuous twenty-four-hour care for patients. As the acuity of illness and the dependency level of patients in acute care hospitals have increased, so have the physical demands on nurses.

On-the-job emotional and intellectual demands have also increased. A larger proportion of the nursing work force, relative to other health workers, is composed of staff who have the dual responsibility of being both homemaker and professional.

The interdependence of medicine and nursing has made for a great deal of tension between the two professions and the tendency of physicians to regard themselves, rather than the patient, as the consumer of the nursing service has also increased the pressure on nurses who are attempting to develop for themselves, a more independent role.

Another singular strain on the nursing staff is the small group milieu in which the work is carried out, making it necessary for the members of this group to continually confront each other in order to resolve conflicts related to their work, the needs of the group and the personalities of its members.<sup>4</sup>

As I see it, though, the greatest barrier to understanding between administrators, medical staff and nurses is not the result of any of these factors but, rather, the fact that the former are predominantly male and the latter predominantly female.

One hundred years ago, John Stuart Mill reminded his readers that "men are men before they are lawyers, or physicians, or manufacturers". I believe the same holds true today and the first step in developing a better understanding between administration and departments of nursing must be recognition of the truth of this observation and application of the fruits of this knowledge.

Nurses must realize and take into account the fact that, in all likelihood, the perspective of male administrators and physicians has been distorted by the predominantly masculine environment of medical schools and management programs, that, as a result, the perceptions of these individuals are probably different from their own, and that it is this conditioning which lies at the heart of the mistrust between

nurses, administration and medical staff.

Unlike male health care workers who have been conditioned, either in the military or sports competition, to accept this type of structure<sup>5</sup>, nurses are uncomfortable in the hierarchic structure of most health care institutions.

Now that they can expect to spend a lifetime in the workforce, many nurses are attempting to restructure this environment. This explains the current interest in primary nursing, unit assignment, total care systems, — modalities of nursing care which allow nurses greater autonomy.

I see this restructuring as a positive approach to our common problem. I believe the response to the current antipathy between nurses, administration and medical staff should be:

1. to recognize that its roots lie deep in the passive and dependent role traditionally assigned to nursing,
2. to develop better means of communicating the realities of the situation, and
3. to adopt methods of organizing nursing care which will permit nurses to escape this role. ♦

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Gabrielle Monaghan, RN, BA, DHA, is director of nursing service at McKellar General Hospital in Thunder Bay, Ontario. She is a graduate of the University of Toronto hospital administration program and of Richmond School of Nursing in Dublin, Ireland and Laurentian University in Sudbury, Ontario.



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# A look at BOOKS

**Community mental health nursing: an ecological perspective** by Jeanette Lancaster. Toronto, Mosby, 1980.

*Approximate price: \$10.95.*

The underlying concept of this book is that "man's health status is the result of the dynamic interaction between his internal environment and the multiple external environments in which he exists". The editor, however, failed to convince this reader. The accompanying articles from her colleagues are very disparate both in content and point of view, and do not further her purpose.

The book has five parts each containing several chapters by different authors. The quality of articles is uneven; some are excellent with new material and fresh suggestions while others are stilted and even superficial in their approach. Although most are written by nursing specialists, little attention is paid to the way in which other nurses might integrate the information into their own practice. Statements like "The nurse...must consider the demands of society," or "must develop strategies that aim towards alleviating the disastrous effects of being poor in an affluent society" leave me overwhelmed. Where do I start? The specific role of nurses in community mental health—what they can realistically do and not do given their position on the health care team—is largely ignored. Grandiose generalizations occasionally overshadow the good material flowing directly from the authors' work, experience, and thought which provokes the reader to go further on his own.

There is information here for a wide audience; clear organization and an index help the reader to discover what will be of interest to her. Nursing students and beginning practitioners will find chapters which orient them to community mental health problems—rape, child abuse, maturational crises.

Nurses more experienced in the field may find in the ideas and alternate frameworks presented new possibilities for their intellectual exploration.

*Reviewed by Susanna Jack, RN, M.Ed.,  
Psychiatry – Outpatient Dept.,  
Montreal General Hospital.*

**Patient and family education: tools, techniques and theory** by Rose-Marie Duda McCormick and Tamar Gilson-Parkevick. New York, John Wiley, 1979.

This book is an enlightening and useful manual for all nurses, especially those in pediatrics. The introductory poem "They heard—but did not remember", is eloquent evidence of the patient/family need for comprehensive, take-home instructions.

The unique aspect of this book is the collection of 79 model instruction packages called "Helping Hands", an outgrowth of H.E.L.P. or Homegoing Education and Literature Program. These model teaching tools are presented in laymen's language with realistically simple, delightful illustrations. These illustrations, while concise, have been executed with a sensitivity that is stress-reducing.

The text offers a detailed description of how to produce your own "Helping Hands" package. An excellent teaching blueprint is also included; it will be appreciated by those helping others learn to teach.

I commend the authors for releasing copyrights on the "Helping Hands"; these instructions may be used as they are, or modified to suit your agency's policies. This manual would be an invaluable addition to any health services library.

*Reviewed by M. Kathleen Cowan, RN,  
BScN, Inservice Educator, Nursing  
Education, The Hospital for Sick  
Children, Toronto.*

**Health Counseling** by Lawrence Litwack, Janice M. Litwack and Mary B. Ballou. New York, Appleton-Century-Crofts, 1980.

*Approximate price: \$13.50.*

The three authors of this text, one of whom is a nurse, are involved in counseling and have written the book for students and professionals whose work is not in counseling per se. They suggest that teachers, community nurses and health educators are among those who will find it useful.

Different forms of counseling are examined and the process of counseling is differentiated from other helping relationships such as teaching and advising. An overview is provided of normal growth and development, current issues in personal health (e.g. physical fitness) and crisis intervention, but the treatment of these is too superficial to be of use. Most nurses know more about both health and counseling than the authors realize.

Possibly the best chapter deals with legal and ethical considerations. Although specifics refer to the U.S., the principles and guidelines have a general application.

Probably the authors have tried to cover too much ground. For example, there is a chapter on group approaches which includes a discussion of leadership as well as group dynamics. Both of these topics are sketchily treated and their comments about leadership are out of date. The reading list provided is so meagre that it might have been better to leave this chapter out altogether.

Although well written and organized, the style is somewhat pedantic in places. This text is too simplistic and deals with its subject too superficially to be of use to nurses.

*Reviewed by Kirsten Weber, RN, MSN,  
associate professor, School of Nursing,  
University of British Columbia.*



**Handbook of infectious disease management** by Cornelis Kolff and Ramon Sanchez. Don Mills, Addison-Wesley Publishing, 1979. Approximate price: \$11.95.

The stated purpose of this book is to "present clinically useful information on infectious diseases in a manner that is both convenient for quick reference and graphic for instruction." This handbook is intended for the use of physicians, nurses and students practicing in the hospital or community setting. While the multidisciplinary, global approach seems like a formidable task, it is nevertheless achieved in a compact 280 pages.

Discussion includes disease entities, initial management, antimicrobial theory, laboratory tests and techniques, and immunization and other control measures. The general format allows for easy access to information, and the diagrammatic approach to diagnosis provides a framework for problem solving. This book does not look at rationales; it is an outline, a map, and as such would be a valuable addition to community, hospital and school libraries. It would be a useful addition to the personal library of a public health nurse, a physician, or any other professional concerned with the control and management of infectious diseases.

*Reviewed by Elfriede Home, RN, BSN, Head Nurse, Infectious Disease Ward, Vancouver General Hospital.*

**The Canadian patient's book of rights** by Lorne Elkin Rozovsky, Toronto, Doubleday, 1980.

Approximate price: \$8.95.

Rozovsky clarifies the purpose of his book by stating that it deals with laws affecting consumers of health care but that it in no way replaces a lawyer for advice on particular questions.

The author writes for consumers and succeeds in making clear legal principles often expressed elsewhere in terms not easily understood by persons lacking a background in law. Included among the topics are health insurance and medicare, the right to the doctor of one's choice, consent to treatment,

standard of care and confidentiality. Each is treated in a clear manner.

The author makes an important distinction between rights and standards of care. "The danger of a bill of rights is that instead of health personnel exercising their professional judgment and acting in a humane manner, they will treat the patient according to the rules and only according to the rules."

Although the book is intended as a guide for consumers, it could well serve students of a variety of occupations within the health service field in Canada.

*Reviewed by Anne D. Thorne, RN, M.Ed., director, Saint John School of Nursing, Saint John, N.B.*

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Obstetric nursing by Olds, London, Ladewig and Davidson. Don Mills, Addison-Wesley Publishing Co., 1980. Approximate price: \$25.00.

The authors have dealt comprehensively with the childbearing process and provided a valuable text for nurses responsible for the care of patients and their families during the reproductive cycle. The concise yet detailed writing style of the authors is a recognized strength. Along with the physiological and psychological aspects of childbearing, this text emphasizes family dynamics, crisis theory and intervention and the nursing process, information important for nursing practice; physiology is another positive feature. Topics related but less significant to the childbearing phase (ie. climacteric) are included, and although described briefly, enhance the understanding of the life cycle.

The text stresses the nursing role in the well-being of the family. The diagrams, photographs, tables, and nursing care plans all add to the effectiveness of the material. However, discussion of the teaching and counseling related to family planning and/or birth control is limited. Considerable explanation of male orgasm is included, but little attention is given to female orgasm. Despite these limitations no significant topic is omitted. The text would be an appropriate choice for baccalaureate nursing programs, health science libraries, maternity units, public health agencies and the personal library of any nurse interested in quality maternal-child health care.

*Reviewed by Shirley MacLeod, associate professor, Faculty of Nursing, University of New Brunswick, Fredericton, N.B.*

Maternal and child nursing by S. Joy Ingalls and M. Constance Salerno. 4th edition. St. Louis, Mosby, 1979.

The fourth edition of this book claims to reflect recent efforts in maternal and child health services "to prevent illness and promote a high level of wellness and also treat disease"; regrettably, the aspects of disease prevention and health promotion receive only token attention.

Like the earlier editions, this text focuses primarily on hospital treatment. However, a considerable amount of material on hospital care of the mother, infant and child is covered in a well organized, clear fashion. Charts and illustrations are numerous and excellent. A phonetic glossary is included and each chapter explains vocabulary.

In keeping with "rising consumer expectations", the obstetrical section has been updated; new material is presented on bonding, breathing exercises and activity during labor, and alternative childbirth arrangements.

Subtle but meaningful word substitutions have occurred, for example, the chapter entitled "Labour and Delivery" is now "Labour and Birth". The pediatric section has been expanded with more discussion of diseases.

Despite the comprehensive title, the nurse interested in health promotion strategies will find little of relevance; this text does not extend beyond hospital walls and is appropriately dedicated to "the bedside nurse". The contribution of the nurse researcher is unrepresented even in the chapter-end bibliographies, and the role of the community nurse is omitted. The book follows the medical model and does not have any conceptual or philosophical framework other than that; family-centered concepts, psychosocial and cultural aspects of care are addressed only superficially. A good example of this superficial treatment is seen in the chapter on the contribution of the male parent; the discussion is confined to a description of anatomy and physiology.

The book is not without value as a compact and practical reference for beginning students, especially since the hospital is still the setting, unfortunately, of much student experience. The practitioner and senior student would doubtless prefer reference material of greater scope and depth. This book contains little of value to either the educator or practitioner wanting to explore new approaches to care of the childbearing family.

*Reviewed by Janet B. Harris, MScN, Clinical Teacher, Maternal-Infant Nursing, Faculty of Nursing, University of Toronto.*

Cardiac rehabilitation: a comprehensive nursing approach by P. Comoss, E. Burke and S. Swails, 334 pages. Toronto, Lippincott, 1979.

Cardiac rehabilitation nursing theories are translated into practical applications in this book using myocardial infarction as a model. Theories and principles are developed for one patient from his admission into the coronary care unit up to and including his discharge one year later from the outpatient section of the program.

The four phases of cardiac rehabilitation divide this book into an easy to read and quick reference text. The case method and use of one patient maintain continuity.

Although it does not provide a comprehensive clinical reference for other cardiac diseases, the book is a valuable guide for a nurse beginning a cardiac rehabilitation program. It would also serve as an excellent model for the student, the generalist nurse or the established cardiac rehabilitation nurse specialist.

*Reviewed by Lorea Ytterberg, clinical director, Medical Nursing, Vancouver General Hospital, Vancouver, B.C.*

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**Manual of orthopedics** by Nancy Hilt and Shirley Cogburn, 846 pages. St. Louis, Mosby, 1980. Approximate price: \$41.50.

This book is the most comprehensive and definitive work available in its field. It is a reference book with a multi-disciplinary approach to the care of orthopedic patients.

Each chapter is well organized and clearly illustrated with hundreds of drawings, color and black-and-white photographs and x-rays. Laboratory data and specific forms are also incorporated. The inclusion of an extensive glossary and a bibliography at the end of each chapter further adds to the effectiveness of this text as a resource.

The manual fills a crucial need for all nurses involved with orthopedic patients: it meets the needs of persons new to the field and those already practicing orthopedic nursing, physiotherapy and occupational therapy. As well, it can be used as a learning text for students and a tool for nursing instructors.

I recommend "Manual of Orthopedics". It is difficult, if not impossible, to fault either the content or format of this manual. Although it is not directed specifically towards orthopedic nursing, the book is a valuable reference for allied health disciplines.

*Reviewed by Marilyn D. Edgren, head nurse - Orthopedics, Halifax Infirmary, Halifax, N.S.*

**Current practice in critical care**  
Toronto, Mosby, 1979.

As a reflection of critical care nurses' concern that nursing practice be based on total patient needs, the authors of this book have presented articles dealing with current perspectives of critical care. As the preface clearly indicates, this book is not a textbook, nor does it seek to provide a consistent approach. The authors are critical care practitioners of various health centers in the United States, who together offer "...alternatives for practice and food for thought".

Committed to continued learning and the importance of appropriate nursing intervention in effective rehabilitation of the whole person, critical care nurses should find the selection of topics in this book pertinent and fundamental in many respects to their adult critical care settings and the expanded role of the critical care practitioner.

This book brings together a selected cross section of perspectives of interest to the new and more experienced critical care nurse, the clinical specialist and the educator. It offers brief historical viewpoints of evolution in critical care.

The first two chapters discuss educational methods and approaches in preparation of practitioners and continuing education. Administration and management is the focus of a brief essay. Pertinent to all critical care settings, physical assessment of the cardiovascular and respiratory systems is developed and nursing application described.

The larger portion of this book is devoted to articles dealing with selected multisystem critical illness, describing pathophysiology, medical, surgical principles and management approaches to treatment, nursing assessment and care. These are interwoven with discussion of pharmacological management, with some overlapping evident, describing agents, their actions and current nursing observations. The final two chapters deal with patients' behavioral responses to critical illness and the environment.

The articles vary in approach and style but the information is clearly presented with a detailed list of content of each article in the table of contents. The material is well researched and referenced and illustrations and tables are clear and pertinent.

The book achieves a formidable task of touching on perspectives of education to management and theory to current scientific research. Although many readers may be familiar with the content, there is considerable merit to having a book which brings it all together. This book offers practical and theoretical approaches on issues fundamental to comprehensive and quality critical care nursing.

*Reviewed by Margaret Eades, RN, BN, Head Nurse, MICU, Montreal General Hospital.*

**Conceptual models for nursing practice** by Joan P. Riehl and Callista Roy. 2d ed. New York, Appleton-Century-Crofts, 1980.

The second edition of this book contains discussion of many more nursing models than did the first edition and includes explanations and descriptions of implementation of the models by individual nurses. However, the models are not critiqued, which leaves the impression that no problems were encountered in the implementation.

The book was difficult to read in places but might be useful as a reference for researchers or graduate students who are considering using one of the models discussed because some models appear not to be published elsewhere.

*Reviewed by Nancy Grant, RN, BScN, PhD, School of Nursing, Dalhousie University, Halifax, N.S.*

**Total patient care - foundations and practice**, 5th ed., by G. Hood and J. Dincher, Toronto, Mosby, 1980.

Approximate price: \$19.25.

This book is presented as a "textbook of medical-surgical nursing designed for students preparing for first entry level into nursing practice and as a reference for practicing nurses". It could well fill these roles but if used for students would require, in several sections, additional guidance through the instructor and/or another text, as the seemingly straightforward explanations require good background knowledge of some topics. On the other hand, this type of presentation does serve as good concise review of basic material for the practicing nurse.

One drawback is the lack of description or diagrams during discussion of certain nursing care responsibilities, eg. percussion in chest physio when caring for patients with respiratory problems, or insertion of nasogastric tubes. Such procedures are not generally included in nursing fundamentals texts and are taught along with the content of a medical-surgical text. In addition, much of the information regarding community and agency organizational patterns, immunization schedules and statistics is American with no Canadian references.

The brevity of explanations makes for quick and easy reading but could prove a detriment to student use of this text unless further explanation in some areas and emphasis on important specific details were offered from some other source.

*Reviewed by Elizabeth Hobden, teaching master, Algonquin College Nursing Program, Pembroke Centre.*

**Orthopedic traction manual** by Andrew Brooker, MD and Gerhard Schmeisser Jr., MD, Baltimore, Williams & Wilkins, 1980.

Approximate price: \$14.95.

Basically this manual intends to teach what to do and how to do it. The authors deal briefly with mechanical aspects of traction such as beds, frames and knots, and apply their knowledge and skills to the types of traction most commonly utilized.

The presentation is clear and precise, with good drawings clearly illustrating the principles of traction. Excellent anatomical drawings are also included.

The manual is recommended as an excellent resource for all medical and para-medical personnel in the day-to-day management of patients in traction.

*Reviewed by Simon Kam, RN, B.Sc., MS (Ed), teaching master, Mohawk College and Richard Blake, RN, McMaster University Medical Centre, Hamilton, Ontario.*



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By Joan Luckmann, RN, BS, MA, Formerly Instructor of Nursing, Univ. of Washington; Highline College, Seattle; Oakland City College; and Providence Hospital College of Nursing, Oakland, CA; and Karen Creason Sorensen, RN, BS, MN, Formerly Lecturer in Nursing, Univ. of Washington; formerly Instructor of Nursing, Highline College; formerly Nurse-Clinical Specialist, Univ. Hospital and Firland Sanatorium, Seattle, WA. 2,276 pp., 817 illus. 1980. **\$40.80.**

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By Dee Ann Gillies, RN, BA, MA, MAT, EdD, Divisional Nursing Director, Surgical Nursing, Cook County Hospital, Chicago; and Irene Barrett Allyn, RN, BA, MSN, PhD, Prof. of Nursing, Univ. of Illinois, Chicago. 745 pp. Nov., 1980. **About \$17.95.**

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## **PHARMACOLOGY: An Introductory Text,** 5th Edition

The fifth edition of this handy reference contains clear, up-to-date discussions of pharmacologic practice and information on new drugs. Case studies, review questions and chapter objectives have been added to facilitate learning. Designed as a basic introduction to drug therapy, the text includes relevant material on anatomy and physiology, as well as a thorough math review focused on dose calculation. Drugs are discussed in relation to their major classifications, with nursing implications integrated throughout.

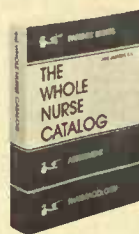
By Mary K. Asperheim (Favaro), BS, MS, MD, Private Practice Pediatrics; Assis. Prof. of Pediatrics, Medical Univ. of South Carolina, Charleston, SC. About 272 pp. Illustd. Ready Feb. 1981. **About \$12.60.**

**NEW IN 1981** Asperheim & Eisenhauer

## **THE PHARMACOLOGIC BASIS OF PATIENT CARE** 4th Edition

Now revised and expanded, this easy-to-use text provides complete information on basic pharmacology. Organized by system and drug categories, this edition includes material on action, toxicity, food and drug interactions, and adult and pediatric dosages. Nursing implications have been added or revised, and the text also contains introductory chapters on drug laws and the nurse's legal responsibilities.

By Mary K. Asperheim (Favaro), BS, MS, MD, Private Practice Pediatrics; Assis. Prof. of Pediatrics, Medical Univ. of South Carolina, Charleston, SC; and Laurel A. Eisenhauer, RN, BS, MSN, PhD, Assoc. Prof. of Nursing, Boston College School of Nursing, Chestnut Hill, MA. About 624 pp. Illustd. Ready March 1981. **About \$23.40.**



Jackson

## **THE WHOLE NURSE CATALOG**

This handy reference/sourcebook enables you to quickly locate the right answers to all types of health care-related questions from patients' rights to taking a health history, to where to find patient teaching materials, to lists of nursing organizations. There is much clinical material, and the appendix contains information on film sources, publishers, state boards of nursing, major poison control centers, normal weights and heights, metric conversions.

By Jane Clark Jackson, RN, BSN, MSN, CNM, formerly Nurse-Midwife, Brooklyn-Cumberland Medical Center, and Maternity and Infant Care Projects of the City of New York, Brooklyn. 743 pp. Illustd. 1980. **\$23.95.**

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The most up-to-date, comprehensive manual of law for nurses is now in a new fourth edition! Dr. Creighton explains those parts of the law applicable to nursing practice and what the nurse's responsibilities are under those laws. Updated and expanded, the fourth edition includes recent court decisions and many of the references cited are from 1978-1980. This new edition is the one single source on law that should be required reading for every nursing student and on the reference shelf of every practicing nurse.

By Helen Creighton, RN, BSN, JD, DLitt, Distinguished Prof. of Nursing, Univ. of Wisconsin-Milwaukee. About 480 pp. Ready Jan. 1981. **About \$18.00.**

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By Thora Kron, RN, BS, Member, Ozark Foothills Home Health Agency Advisory Group; with contributions by Ellen Durbin, RN, Med, MBA, Consultant for Management and Nursing, San Francisco, CA, formerly Asst. Administrator for Patient Care Services, Barnert Memorial Hospital Center, Paterson, NJ. About 238 pp. Illustd. Ready Jan. 1981. **About \$11.95.**

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**Helping the retarded child in the elementary school years** by John B. Fotheringham and Joan Morris. Toronto, University of Toronto, 1979.

*Approximate price: \$5.95.*

This text on assisting the mentally retarded child is unique: it is directed towards both families and professionals. It offers little new to those familiar with the handicapped, but it is suitable for those having limited experience with retarded youngsters. It provides current information on some of the many issues that families and helpers must contend with.

The classification of mental retardation is clarified, and considerable attention is given to the problems and benefits of labelling. Assessment of children, program planning and school arrangements are dealt with in some detail. This information would be of value to the nurse involved in hospital or community care of handicapped children. The text is sometimes rather confusing; the benefits of integration and modelling are outlined early on, but later the author states "special schools are probably more appropriate for T.M.R. children." This seems to reflect the confusion experienced by both professionals and families as they attempt to "normalize" care for these children.

The section on counseling and community services will be of particular interest to nurses as these are the areas in which we often become involved.

This book would probably be most useful to nurses unfamiliar with the problems of the retarded child and family.

*Reviewed by Sheila Cameron, Assistant Professor, School of Nursing, University of Windsor.*

**People, patients and nurses: a guide for nurses toward improved interpersonal relationships** by Jennie Wilting. 130 pages. Edmonton, University of Alberta Press, 1980.

*Approximate price: \$10.00*

The area of communication and interpersonal relations has been one of great concern for many nurses. Often, an accumulation of minor emotional happenings can bring on feelings of frustration and helplessness. People, patients and nurses, a unique and timely paperback, is an excellent guide to help nurses look at such problems in a systematic way. The book lists and discusses each problem under three logical headings: problems arising from relationships with self, patients and co-workers.

The section on problems arising from the relationship with self, offers a good explanation of the concept of accepting oneself. To accept yourself, you must know yourself in terms of your characteristics: are you ambitious? kind? intelligent? In determining your own character, you must be honest and

non-judgmental. Learning to accept your true feelings is essential before you can decide how you will respond to the problem.

The same principles are applied in the second section on problems arising from relationships with patients. Several excellent examples are drawn from the author's 25-year experience in the mental health field.

Problems arising from relationships with co-workers are cited as the cause of more unhappiness and discontent than any other situation. Some guidelines for dealing with minor problems are discussed, again using the principles outlined in the preceding chapters.

While the information in this book is not new, I recommend it to all nurses. The examples could be used in classroom or clinical discussion groups to emphasize interpersonal relationships and communication, and the role they play in problem prevention and solution.

The title of the book "People, patients and nurses", seems rather ambiguous — I would hope patients and nurses are people too. This readable book would be of interest to anyone interested in guidelines for personal improvement and more satisfactory interpersonal relationships.

*Reviewed by Eileen French, assistant professor, School of Nursing, University of Ottawa, Ottawa, Ontario.*

**Review of hemodialysis for nurses and dialysis personnel** by C.F. Gutch and Martha H. Stoner. 3d edition. Mosby's Comprehensive Review Series, Toronto, Mosby, 1979.

*Approximate price: \$17.00.*

As the title suggests, this third edition provides a concise, easy to read review of the basic principles of hemodialysis, renal physiology and chemistry, available dialysis equipment, and the common problems and complications associated with acute and maintenance hemodialysis.

As in the two previous editions the authors have retained their unique question and answer format, making the book easy to read and digest in parts. Thanks to the extensive index, the book also serves as an excellent quick reference when problems or questions arise in the dialysis unit. A list of basic reference texts that are recommended for a small ward library is also included.

There is a short discussion of home care, peritoneal dialysis and some consideration of the implications of long term dialysis for the patient, family and society; almost all important subject areas are mentioned. This book is an excellent reference to have on any dialysis unit.

*Reviewed by Marcia Wiltse, RN, Staff Nurse, Regina General Hospital, Hemodialysis Unit, Regina, Sask.*

**Teaching tomorrow's nurse: a nurse educator reader** by Susan Kooperstein Mirin, 1st ed. Wakefield, Massachusetts Nursing Resources Inc., 1980.

*Approximate price: \$10.95.*

This is an anthology of 24 articles submitted to the Nurse Educator and divided into seven major areas: preparing students for contemporary practice, clinical teaching, the use of nursing theory, the RN student, the adult learner, helping students succeed and faculty development.

The author suggests the articles are practical, readable and based on sound theoretical foundations. While many of them do whet your appetite, several do not provide the reader with sufficient information and/or detail to replicate the authors' instructional design or strategy.

Educators are continually expressing a need for information on clinical teaching, preparing students for expanded practice and the adult learner. However, of the three articles devoted to clinical teaching, one deals with clinical conferences, one with anecdotal records and one with a student experience with well adults. The section on preparing students for expanded practice runs the gamut of health assessment to discharge planning. The area of the adult learner addresses a competency based nursing program, individualized instruction and an andragogical experience with graduate students.

The articles are well written and the book is of general interest to educators, but it certainly would never be called an essential text.

*Reviewed by M. Kaye Fawdry, assistant professor, School of Nursing, University of Windsor, Windsor, Ontario.*

**Research in nursing practice** by Donna Diers. New York, J.B. Lippincott Co., 1979.

This publication should be a welcome addition to the bookshelf of anyone interested in finding answers to clinical nursing problems. The importance of rigor in research is tempered with realism; the author gives credit to practitioners' hunches and stresses choosing tools that will help tell something important about nursing practice. The mystique that research requires knowledge and skill only obtainable by a few is counteracted by a positive assumption that all nurses can and should do research.

The reader is introduced early to the idea that research begins with a problem that must be translated into a question answerable through research. The four chapters on study design, the most valuable section of the book, are ordered progressively starting with naming theory and ending with prescriptive theory. Each design is considered within the framework of the nursing process. These chapters would serve as a good reference while research is in progress.



The examples used in this text all deal with research on nursing problems. The notes at the end of each chapter are very helpful, providing other sources for more specific information and offering further clarification of chapter content.

One unique feature is the description of a study by the author using information gathered while she was a participant observer in a research class; a personal and practical demonstration of research in action.

This book is a very useful text for those concerned with the systematic study of nursing practice.

*Reviewed by Sheila Stanton, associate professor, University of British Columbia, School of Nursing, Vancouver, B.C.*

**Geriatric clinical protocols** by L.J. Pearson and M.E. Kothhoff.  
Philadelphia, Lippincott, 1979.  
Approximate price: \$19.00.

This book provides clear, factual information for nursing care of the geriatric patient. Set in the format of clinical protocols, it is one of the few comprehensive books available for specific reference in caring for the elderly.

The book is divided into two segments: unit one discussing protocols for presenting complaints in the elderly and unit two protocols for chronic conditions common to the elderly. The units on urinary incontinence and depression, two common problems in the elderly, requiring much nursing input, are rarely addressed in adequate detail in alternate texts.

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Applications are invited for registered nurses for a 62 bed acute care hospital located in south-eastern British Columbia. Applicants must be registered or eligible for registration in the Province of British Columbia. Salary: \$543.00/month (unregistered) or \$1624.00 - \$889.00/month (registered). Benefits in accordance with R.N.A.B.C. plus planned orientation, regular inservice programs, master rotation, 8 hour shifts, staff rotate between medical/pediatrics and surgical/obstetrics unit every month. Residence accommodation within walking distance, ski resort within 3 miles of hospital. Apply in writing to: Director of Nursing Service, Fernie District Hospital, Box 670, Fernie, British Columbia V0B 1M0.

A guide to physical examination by Barbara Bates. Second edition. Toronto, J.B. Lippincott, 1979.

This second edition is markedly improved by the addition of an excellent introductory chapter on interviewing and the healthy physical. More explanatory diagrams, photos and descriptions are used to aid the student in the examination procedure and in identifying abnormalities. This book also provides a good sample method for recording a complete history and physical in a continuous smooth flow; the drawback of this method is that it is lengthy and makes limited use of abbreviated terms.

The design of the book is helpful in that the sequence of chapters follows the same order used in carrying out a physical exam. The chapters on eyes, ears, nose and throat seem to scatter information making them difficult to follow.

The many pictures used surpass pages of explanation in guiding a student through the physical examination procedure. The addition of color plates of an eardrum, normal and abnormal fundi and skin lesions and rashes would enhance the otherwise good illustrations.

The book does not discuss problem-oriented history taking and recording, a serious gap in a book of this sort. Hopefully the third edition will remedy this problem.

*Reviewed by Lissa Proulx, Nurse Practitioner, currently employed as a nurse practitioner, Kiv Health Centre of General Practice, N.*

General Duty R.N. position. 10-bed acute care nursing: a Kootenay region of B.C. RNABC Contract. Send by Eloise R. Community Hospital, Box Saunders British Columbia V0G 1S0.

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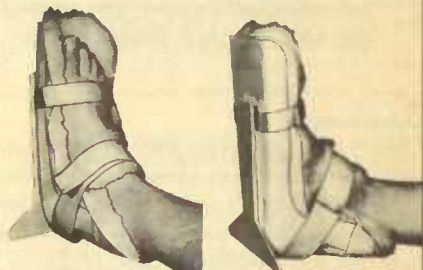
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It suggests, this third is a concise, easy to read basic principles of renal physiology and dialysis equipment, non problems and associated with acute and hemodialysis. The two previous editions have retained their unique answer format, making the book read and digest in parts. The extensive index, the book is an excellent quick when problems or questions dialysis unit. A list of reference texts that are needed for a small ward library is included. There is a short discussion of peritoneal dialysis and some of the implications of dialysis for the patient, society; almost all important as are mentioned. This book is a reference to have on any unit.

Commission will assess the Reviewer bilingual. Language professor, School of Windsor, Windsor.

**Research in nursing**  
Donna Diers. New  
Lippincott Co., 1980.

This publication should be a welcome addition to the books of anyone interested in finding answers to clinical nursing problems. The importance of rigor in research is tempered with realism; the author gives credit to practitioners' hunches and stresses choosing tools that will help tell something important about nursing practice. The mystique that research requires knowledge and skill only obtainable by a few is counteracted by a positive assumption that all nurses can and should do research.

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by Marcia Wiltse, RN, Staff  
Solicitor General Hospital,  
Saskatoon Unit, Regina, Sask.



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Applications are invited for registered nurses for a 62 bed acute care hospital located in south-eastern British Columbia. Applicants must be registered or eligible for registration in the Province of British Columbia. Salary: \$1543.00/month (unregistered) or \$1624.00 - \$1889.00/month (registered). Benefits in accordance with R.N.A.B.C. plus planned orientation, regular inservice programs, master rotation, 8 hour shifts, staff rotate between medical/pediatrics and surgical/obstetrics unit every 3 months. Residence accommodation within walking distance, ski resort within 3 miles of the city. Apply in writing to: Director of Nursing Service, Fernie District Hospital, Box 670, Fernie, British Columbia V0B 1M0.

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**Experienced nurse** (eligible for B.C. Registration) required for full time position in our lovely cottage hospital on northern Vancouver Island. Apply to the: Port McNeill and District Hospital, P.O. Box 790, Port McNeill, British Columbia V0N 2R0.

## British Columbia

**Experienced General Duty Nurses**, preferably eligible for B.C. Registration, required for 71-bed accredited hospital on the Sunshine Coast of British Columbia. Salaries and benefits according to RNABC agreement. Residence accommodation available. Apply in writing to: Personnel Officer, St. Mary's Hospital, Box 7777, Sechelt, B.C. V0N 3A0.

**General Duty Nurses** required immediately for a ten-bed acute and ambulatory care hospital located in Stewart, B.C. Stewart has a population of 2000 and is Canada's northernmost ice-free port with transportation, mining and construction as its primary industries. There are excellent school facilities. A few of the many sports offered are boating, fishing and, in the modern community pool, swimming. Stewart General Hospital is affiliated with the Prince Rupert Regional Hospital and nurses are encouraged to take part in the Inservice education programmes at both hospitals. Salary rates are according to the RNABC contract and for a general duty RN the ranges are: May 1, 1980—\$1624-\$1889 plus \$26.87 northern allowance. Jan. 1, 1981—\$1700-\$1965 plus \$28.12 northern allowance. Fringe benefits include: 20 days paid annual vacation; 5 days marriage leave; annual educational leave, in addition to the other usual health care insurance and monetary benefits. We are eager to help you relocate. For further information please call COLLECT: (604) 624-2171, ask for Mrs. L. Bremner, Director of Nursing.

**O.R. Head Nurse** required for an active 103-bed acute care hospital. Must be eligible for B.C. Registration. Post graduate training & experience necessary. R.N.A.B.C. Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

**General Duty Nurses** required for an active, 103-bed hospital. Positions available for experienced R.N.'s and recent Graduates in a variety of areas. RNABC Contract in effect. Accommodation available. Apply to: Director of Nursing, Mills Memorial Hospital, 4720 Haugland Avenue, Terrace, British Columbia V8G 2W7.

St. Paul's Hospital invites applications from (B.C. Registered) R.N.'s for a 550 bed teaching hospital located in downtown Vancouver, B.C. Easy access of recreational facilities and good living accommodations. Salary 1981 rates—\$1700.00-\$1965.00 per month. Full-time and Vacation Relief positions available in all clinical areas. (No Pediatrics). Please apply in writing to: Mrs. S. Howie, Nursing Administrative Assistant, Personnel Department, 1081 Burrard Street, Vancouver, British Columbia V6Z 1Y6.

## Newfoundland

**Faculty position** available in Degree/Diploma Program in Outpost Nursing and Nurse-Midwifery. Knowledge and experience in Community Health and Primary Care Nursing in Northern and Rural Areas. Apply to: Margaret D. McLean, Director & Professor, School of Nursing, Memorial University of Newfoundland, St. John's, Newfoundland A1C 5S7. Phone (709) 737-6695.



## Northwest Territories

The Stanton Yellowknife Hospital, a 72-bed accredited acute care facility requires registered nurses to work in medical, surgical, paediatric, obstetrical or operating room areas. For further details concerning salary and benefits contact: Lynette McLeod, Personnel Officer, Box 10, Yellowknife, N.W.T. X1A 2N1. (403) 873-3444 (Collect).

## Ontario

**Urgently Needed Registered Nurses**—general hospital in small community. Applicants proficient in both official languages preferred. Apply to: Mrs. P. Vehkalahti, Director of Nursing, Bingham Memorial Hospital, Box 70, Matheson, Ontario P0K 1N0 (705) 273-2424.

**Registered Nurses required.** Hospitals located on James Bay at Attawapiskat and Fort Albany. Good salary scale plus Northern Allowance. Accommodations provided. Enjoy a Northern Experience. For further information, contact: The Administrator, James Bay General Hospital, P. O. Box 370, Moosonee, Ontario P0L 1Y0.

**Registered Nurses—Full-time and part-time** Registered Nurses currently registered in Ontario required for a new 136 bed community hospital. Recent medical, surgical, special care unit and/or obstetrical experience would be an asset. Qualified applicants are invited to submit their resumes outlining qualifications and experience to: Mrs. G. Saxton, Director of Personnel, Temiskaming Hospital, New Liskeard, Ontario P0J 1P0.

St. Joseph's Health Centre is a West Toronto Acute and Chronic Care Hospital. We require: Registered Nurses, Full & Part Time, I.C.U./C.C.U. This is a new intensive coronary care unit which contains the most modern technological equipment available. Nurses are also needed in: Emergency Department. Nurses will find our location in West Toronto, on the Queensway, overlooking Lake Ontario, ideal for commuting. We offer excellent benefits and competitive salary. Weekdays, Telephone 534-9531 Ext. 543, Week-ends & After Hours Ext. 303. St. Joseph's Health Centre, 30 The Queensway, Toronto, Ontario M6R 1B5.

## Saskatchewan

**Diploma Nursing Instructor (Psychiatric Nursing)**—Saskatchewan Continuing Education, Wascana Institute of Applied Arts and Sciences, Regina requires an Instructor who will be a member of a team teaching Psychiatric nursing to second year diploma nursing students during eight week clinical rotations. Primary responsibilities include classroom instruction, planning and supervising clinical experience in a psychiatric setting and related community agencies; evaluating students and providing guidance to assist them to meet program objectives; assisting in the on-going up-date and revision of curriculum. Applicants will have a Bachelor's degree in Nursing, be eligible to register as a nurse in Saskatchewan, and have two years' clinical experience in a psychiatric setting. Supervisory or teaching experience or preparation preferred. Salary: \$21,168 - \$28,248 (with B.Sc.N.); \$23,040 - \$30,132 (with M.Sc.N.). (Instructor, Technical Institute). Competition No.: 501010-0-4660; Closing: As soon as possible. Forward your application forms and/or resumes to the Saskatchewan Public Service Commission, 3211 Albert Street, Regina S4S 5W6, quoting position, department and competition number.

## Quebec

**Concordia University—Department of Nursing Science\*** requires a Director/Professor for the newly reorganized Nursing Department. Commencing date: June 1, 1981 or as soon as possible. Requirements—Educational: M.Sc.N. essential; Doctorate degree preferred (Ph.D., D.Sc.N. or D.Ed.); French/English bilingualism an asset. Experience: University teaching and administrative experience essential. Salary & Prerequisites: Salary negotiable within present North American scales. Concordia offers excellent fringe benefits. Candidates should apply sending complete curriculum vitae, with the names, addresses and phone numbers of 3 referees to: Dr. Maurice Cohen, Dean, Division III, Arts and Science, Concordia University, 1455 de Maisonneuve Blvd. West, Montreal, Quebec H3G 1M8. \* Opening Fall, 1981, subject to government approval.

**Concordia University—Department of Nursing Science\*** requires faculty at all ranks for a newly organized Nursing Department. Educational Qualifications: M.Sc.N. (minimum); Doctorate an advantage; Bilingual (French/English) an advantage. Experience: 2 years clinical; 2 years teaching; university teaching experience an advantage. Salary & Prerequisites: Commensurate with education, experience. Concordia offers excellent fringe benefits. Candidates should send their curriculum vitae together with the names, addresses and phone numbers of three referees to: Professor Muriel Upchurch, Ph.D., Health Education/Community Nursing, 7141 Sherbrooke Street West, Montreal, Quebec H4B 1R6. \* Opening Fall, 1981, subject to government approval.

## Saskatchewan

Two Registered Nurses are needed for a 12-bed acute care facility, 430 miles northwest of Saskatoon. Wages and benefits as per SUN Contract. Living accommodations available. Apply to: Director of Nursing, St. Martin's Hospital, LaLoche, Saskatchewan S0M 1G0, or call collect (306) 822-2011.

**One General Duty Registered Nurse required.** 11 bed hospital. Duties to commence as soon as possible. Salary according to S.U.N. Contract. Residence accommodation available. Please contact: Margaret Friesen, D.O.N., Neilburg and District Union Hospital, Neilburg, Saskatchewan S0M 2C0. Phone: (306) 823-4262; 823-4703.

**Registered Nurses and Registered Psychiatric Nurses** (eligible for Saskatchewan registration) required for 340 fully accredited extended care facility. For further information contact: Personnel Department, Souris Valley Extended Care Hospital, Box 2001, Weyburn, Saskatchewan, S4H 2L7.

## United States

**RN/Staff & Management Positions**—Kaiser-Permanente, the country's largest Health Maintenance Organization, currently has excellent opportunities available in our 583-bed Los Angeles Medical Center. Located 7 miles from downtown Los Angeles, close to many of California's finest Universities, this teaching hospital offers RN's a unique chance to further their careers in such areas as: OR, Med/Surg, Maternal Child Health & Critical Care. Management positions are also available. Kaiser offers an attractive array of fringe benefits including relocation assistance, full medical, dental & health coverage, continuing education advanced training available in the Nurse Practitioner & CRNA Programs, individualized orientation, tuition reimbursement, and no rotating shifts. New graduates are always welcome and encouraged to inquire. For more information, please write or call collect: Ann Marcus, RN, Kaiser Hospital/Sunset, 4867 Sunset Blvd., L.A., California 90027. (213) 667-8374.

## United States

**California**—Sometimes you have to go a long way to find home. But, The White Memorial Medical Center in Los Angeles, California, makes it all worthwhile. The White is a 377-bed acute care teaching medical center with an open invitation to dedicated RN's. We'll challenge your mind and offer you the opportunity to develop and continue your professional growth. We will pay your one-way transportation, offer free meals for one month and all lodging for three months in our nurses residence and provide your work visa. Call collect or write: Ken Hoover, Assistant Personnel Director, 1720 Brooklyn Avenue, Los Angeles, California 90033 (213) 268-5000, Ext. 1680.

**Total patient care with all licensed personnel is our goal!** Staff RNs currently interviewing for part-time and full-time positions. Full service, except psych, progressive 156-bed accredited acute general hospital. Located within 60 minutes from LA, the ocean, mtns., and the desert. Orientation and staff development programs. CEUs provider number. Parkview Community Hospital, 3865 Jackson Street, Riverside, California 92503. Write or call collect 714-688-2211 Extension 217. Betty Van Aernam, Director of Nursing.

**RN'S**—Our Florida hospitals need you! Join the many Canadian RN's who are currently enjoying Florida's Gulf Coast beaches, sun, and exciting recreational activities. We will provide work visas, help you locate a position, find housing, and arrange your relocation. No Fees! Call or write: Medical Recruiters of America, 3421 West Cypress St., Tampa, Florida 33607 (813) 872-0202.

## Miscellaneous

To all alumni members of the Edmonton General Hospital School of Nursing wishing to notify us of their change of address, include your name, year of graduation, and please forward to: Station F, Box 8124, Edmonton, Alberta, Canada T6H 4N9.

**Adventure Holidays:** Camping Safaris, Overland Expeditions and Fun Experiences. We offer trips from one week to 3 months in: Canada, USA, Europe, Africa, Asia, South and Central America, Australia, New Zealand and the Caribbean. For FREE catalogue, contact your travel agent, or apply to: Goway Travel, 53 Yonge St., Suite 101, Toronto, Ontario M5E 1J3. Phone: 416-863-0799. Telex: 06-219621.

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**J. Philip Knight-Sheen**  
1635 N.E. Loop 410  
Suite 501  
San Antonio, Texas 78209


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Modern 300+ bed community hospital seeks a highly qualified nursing administrator. The position reports to the chief executive officer. The hospital is a regional center providing sophisticated medical and nursing care.

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Circular and triangular nursing stations with no long corridors means fewer steps for you and security for your patients. You will find systems that free you for patients care such as HBO Computerized Data Systems and Unit Dose Medication System. Specialize in such areas as Coronary Care, Oncology, Open Heart, Intensive Care and light risk perinatal center.

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Last year, alone, we held 392 development classes designed to build on previously acquired knowledge and skills. And 60 inservice classes were held for continued learning necessary to follow through with hospital job expectations. We now offer a 6 month OR course and a 6 week critical care course. We also pay 75% tuition and books toward an advanced nursing degree.

### St. Paul, Minnesota

The Twin Cities of Minneapolis/St. Paul are only 280 miles from the Canadian border. Cultural and entertainment happenings are big-city exciting and the people are small-town friendly. There's a quality of life that's hard to describe, why not come down and we'll show you.

If you are eligible for a Minnesota State License and are looking for that "Something Better" to put real meaning into your nursing career, **CALL BARB BLAND COLLECT AT 612-298-8114** or write:

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Available positions include both administrative and staff level nursing. Requirements depend on the position — at staff level a minimum 2-3 years current experience in an acute care hospital or clinic setting. Current R.N. license in one of the Provinces. Single status contracts are offered for 18 or 24 month periods.

Attractive salaries with excellent benefits including air transportation, furnished lodging, generous vacation, bonus pay and bonus leave.

Interested in this once in a lifetime opportunity? For more details, please send professional resume to:

**Kathleen Langan**  
Hospital Corporation International, Ltd.  
Two Robert Speck Parkway, Ste. 750  
Mississauga, Ontario L4Z 1H8

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## Nursing Opportunities in Vancouver Vancouver General Hospital

If you are a Registered Nurse in search of a change and a challenge - look into nursing opportunities at Vancouver General Hospital, B.C.'s major medical centre on Canada's unconventional West Coast.

Recent graduates and experienced professionals alike will find a wide variety of positions available which could provide the opportunity you've been looking for. Applications are invited for the following positions:

General Duty (\$1624 - \$1889 per month 1980 rates)

Head Nurse  
Nurse Clinician  
Nurse Educator  
Supervisor

For those with an interest in specialization, challenges await in many areas such as:

Neonatology Nursing  
Intensive Care (General & Neurosurgical)  
Inservice Education  
Cardio-Thoracic Surgery  
Coronary Care Unit  
Burn Unit  
Hyperalimentation Program  
Paediatrics Psychiatry  
Renal Dialysis & Transplantation  
Extended Care

If you are a Nurse considering a move please submit resume to:

**Mrs. J. MacPhail**  
Employee Relations  
Vancouver General Hospital  
855 West 12th Avenue  
Vancouver, British Columbia  
V5Z 1M9

## Assistant Director, School of Nursing

### *Brandon Mental Health Centre*

**Duties:** The incumbent carries both teaching and administrative responsibilities; assists the director in planning, directing and evaluating programs carried out by school faculty. In the absence of the Director, assumes full administrative responsibilities.

**Qualifications:** Relevant degree in Nursing or Health Administrative plus R.P.N. or R.N. supplemented by two years' teaching experience at school of nursing.

**Salary:** \$20,205-\$27,541 per annum.

**Competition No.:** CN-843. Closing: Immediately.

Please send completed Civil Service application, quoting competition number, directly to:

**Dept. of Health**  
Personnel Management Services  
270 Osborne Street North  
Winnipeg, Manitoba  
R3C 0V8

**MANIT<sup>BA</sup>**



# Royal Alexandra Hospital

This 938 bed active treatment hospital invites applications from nurses across Canada.

We offer experience in all areas of patient care including intensive care, neonatal intensive care and obstetrical perinatology. The extended work day and compressed work week is currently in effect in the Intensive Care areas and Emergency.

Applicants must be eligible for registration with the Alberta Association of Registered Nurses.

Please direct inquiries to:

Mrs. D. Kivell  
Personnel Officer  
Nursing Recruitment  
Royal Alexandra Hospital  
Room 1108  
10204 Kingsway  
Edmonton, Alberta  
T5H 3V9



## NURSES

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We are Canada's Medical Services. We provide health care to the peoples of Canada's north country. We'd like to have you on our team. If you qualify you will begin your career at one of our outpost nursing stations, an important member of a small community. Here you will be able to use your **self-reliance, good judgment and sense of responsibility**, supported by experienced senior nursing and medical personnel, both "on call" and on "routine visits".

There will be **opportunities for promotion** - for moving to other locations across Canada in our hospitals, outpost nursing stations, health centres, major clinics, occupational health units and in other health areas.

Salaries are supplemented by special allowances, overtime compensation and pension benefits, in addition to holidays and an opportunity for travel.

For further information, mail the coupon below.

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Medical Services Branch  
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*Foothills Hospital*

*Calgary*

Director of Nursing

The Hospital invites applications for the position of Director of Nursing. Foothills Hospital is a 761 bed teaching hospital and referral centre for Southern Alberta.

This key position requires a dynamic nursing executive with proven management experience, preferably in a teaching hospital. The successful applicant should have advanced educational preparation in nursing or health administration complemented by senior nursing administration experience, plus strong interpersonal skills, high energy and the ability to successfully introduce innovative changes.

Interested applicants are asked to submit a detailed resume to:

Director of Personnel  
Foothills Hospital  
1403 - 29 Street N. W.  
Calgary, Alberta  
T2N 2T9



# Choose a Nursing Career in Canada's Ocean Playground



The Victoria General Hospital, Halifax, Nova Scotia is the Maritime's largest teaching hospital. Close association with Dalhousie University and our own extensive continuing education program provide excellent opportunities for learning and career development.

The Victoria General Hospital offers a variety of nursing specialties for experienced people looking for a professional environment and challenge. Victoria General Nurses have full civil service benefits.

- **GENERAL DUTY NURSES** work in our 28 general nursing units, each of which have specific sub-specialties in Medicine and Surgery.
- **INTENSIVE CARE NURSES** are part of five specialized units such as Coronary, Cardiovascular, Medical, Surgical and Neurosurgery.
- **SPECIALTY AREA NURSES** work in the Burn Unit, Renal Unit, Emergency, Operating Room, Recovery Room or Out-Patients.
- **NURSING ADMINISTRATION.** We encourage promotion through an on-going program of leadership development.

Please quote Competition Number: 80-310.

For details on nursing opportunities contact:

Mrs. Betty Elliot, R.N.

Personnel Department, Victoria General Hospital

5788 University Avenue

Halifax, Nova Scotia B3H 1V8

Telephone: 1 (902) 428-3484



## Director of Nursing

Churchill Health Centre, Churchill, Manitoba requires a Director of Nursing.

Churchill Health Centre is a community-governed health and social development service encompassing public health, social services, medical-dental ambulatory and in-patient care. It serves Churchill and the surrounding area of Manitoba as well as being a referral centre for the Keewatin District of the Northwest Territories, and varies from active community clinic and outreach services to a 31 bed in-patient unit.

The successful candidate will be able to organize and administer all the patient care services of Churchill Health Centre including the in-patient unit, ambulatory, clinic nursing services and a small surgical suite. This is a senior professional position that offers challenge and excitement to the successful applicant who will have an opportunity to exercise innovative ability in meeting the needs of patients from the Keewatin while working within a unique community oriented organization.

**Qualifications:** We require a nurse who is eligible for registration in Manitoba, preferably with a degree and/or administrative experience.

**Salary:** Will commensurate with qualifications and experience; but not less than \$23,000.00 per year.

**Benefits:** Northern Living Allowance, 20 days paid vacation annually with removal assistance, inward and outward removal assistance, group life, pension and other benefits available and fully modern furnished subsidized housing.

Apply to:

Executive Director  
Churchill Health Centre  
Churchill, Manitoba

ROB 0E0

Phone: 1-204-675-8881, ext. 125

## The Izaak Walton Killam Hospital for Children

### Assistant Head Nurse Neo-Natal

The I.W.K. Hospital for Children requires an Assistant Head Nurse for our Neo-Natal Unit, which is a 32-bed referral centre providing intensive, intermediate and convalescent care.

Applicants must be a graduate of an accredited School of Nursing and eligible for registration in Nova Scotia. Degree or Diploma in Nursing Service Administration is preferred. Must have a good knowledge of Neo-Natal nursing principles and techniques.

Inquiries and applications should be directed to:

Karen Lyle, Personnel Officer  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
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## Registered Nurses

Full time and part time Registered Nurses required for modern accredited 60 bed active general hospital, for Supervisory and General Duty positions.

12 hour shifts in effect.

Please apply in writing to:

(Miss) E. Locke, Reg. N.  
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Lady Minto Hospital  
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## McMaster University Educational Program For Nurses In Primary Care

McMaster University School of Nursing in conjunction with the School of Medicine, offers a program for registered nurses employed in primary care settings who are willing to assume a redefined role in the primary health care delivery team.

**Requirements** Current Canadian Registration. Preceptorship from a medical practitioner. At least one year of work experience, preferably in primary care.

For further information write to:

Joan Eagle, Director  
Educational Program for Nurses  
in Primary Care  
Faculty of Health Sciences  
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For information and application write to:  
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Department of Nursing  
FootHills Hospital  
1403 - 29th St. N. W.  
Calgary, Alberta T2N 2T9

## Prince George Regional Hospital

Positions available for experienced nurses or nurses interested in developing their skills in specialty nursing—Operating Room, ICU/CCU, Neonatology Nursing. Positions also available in general nursing areas and float pool. Must be eligible for B.C. Registration.

- Well developed orientation program
- Inservice Education
- Expanding Operating Room and Obstetrical Suite
- 10 bed ICU/CCU

Prince George Regional Hospital is a 340 bed acute regional referral hospital with a 75 bed extended care unit and has a planned program of expansion.

For further information contact the:

Personnel Department  
Prince George Regional Hospital  
2000—15th Avenue  
Prince George, British Columbia  
V2M 1S2

## University of British Columbia M.Sc. Program (Health Services Planning)

A program is offered which is specifically designed for persons with experience in health and/or social services. Applicants must be graduates in one of the health, social or life sciences, or commerce. Preference will be given to practising health professionals or managers who have 4-5 years experience.

It is anticipated that graduates will find appointments at relatively senior planning-policy levels of Canadian or international health services or in health care research.

Students taking the research option are eligible to apply for National Health Grant Student Fellowships.

Applications should be completed by February, 1981.

For details, write to:

Morton M. Warner, Ph.D.  
Director Epidemiology Program in  
Health Services Planning  
Department of Health Care &  
Epidemiology  
University of British Columbia  
2975 Westbrook Mall  
Vancouver, B.C. V6T 1W5  
or Telephone (604) 228-2772

## Trail Regional Hospital Trail, British Columbia

Position Open

### General Duty Nurse Head Nurse

Applications are invited for the following full-time position of Head Nurse on:  
2nd Medical/Cardio Pulmonary Rehab

The successful candidate must have demonstrated supervisory ability, including ability to direct a staff of various personnel categories.

Previous and recent management experience and post-basic academic training considered an asset.

Hours of Work: Days - Monday to Friday.

Salary: As per R.N.A.B.C. Contract.

Position Available: Immediately.

Apply in writing to:

Mr. Lawrence H. Jones, BScN., R.N.  
Assistant Administrator, Nursing Services  
Trail Regional Hospital  
Trail, British Columbia  
V1R 4M1

## Registered Nurses

300 bed Accredited general hospital in Vancouver requires full-time, part-time and casual R.N.s for general duty and ICU nursing. Candidates should be eligible for registration in B.C. Recent nursing experience preferred. ICU candidates must have previous ICU experience.

Please apply to:

Employee Relations Department  
Mount Saint Joseph Hospital  
3080 Prince Edward Street  
Vancouver, B.C.  
V5T 3N4



## Royal Jubilee Hospital Victoria, B.C.

Applications are invited from Registered Nurses or those eligible for B.C. Registration with recent nursing experience.

Positions are available in all services of this 950 bed accredited hospital which includes Acute and Specialty Care, Obstetrics and Paediatrics, Psychiatry and Extended Care for Full Time, Part Time and Casual Employment.

Benefits in accordance with R.N.A.B.C. contract.

Please send resume to:

Director of Nursing  
Royal Jubilee Hospital  
1900 Fort St.  
Victoria, B.C.  
V8R 1J8

## Registered Nurses required

Applications are invited from Registered Nurses interested in full-time employment in a fully-accredited, 65-bed personal care home in Notre Dame de Lourdes, Manitoba, 90 miles Southwest of Winnipeg.

Excellent personnel benefits as well as rotations of Days/Evenings with every other weekend off are offered. Salary range is in accordance with current contract.

Qualified individuals are directed to forward their applications to the attention of:

Jacqueline Thérout  
Director of Nursing  
Foyer Notre Dame Incorporated  
Notre Dame de Lourdes, Manitoba  
R0G 1M0

Telephone: (204) 248-2092

## The Izaak Walton Killam Hospital For Children

### Staff Nurses

The I.W.K. Hospital for Children has vacancies for Staff Nurses on our Intensive Care Unit and Neo-Natal Unit. Must be a graduate from an accredited School of Nursing and be eligible for registration in Nova Scotia. Previous pediatric experience would be an asset.

Inquiries and applications should be directed to:

Karen Lyle  
Personnel Officer  
The I.W.K. Hospital for Children  
P.O. Box 3070  
Halifax, Nova Scotia  
B3J 3G9

## Registered Nurses

Registered Nurses are required for an 87 bed accredited Hospital in Northern Ontario.

Applicants must be eligible for Registration with the College of Nurses of Ontario.

Bilingualism is an asset.

Salary and Fringe Benefits in accordance with O.N.A. Contract.

Temporary residence accommodation is available.

Please apply in writing to:

Director of Nursing  
Sensenbrenner Hospital  
10 Drury Street  
Kapuskasing, Ontario  
P5N 1K9



## Registered Nurses

We are presently seeking Nurses eligible for registration in the province of Ontario who would like to work in one of Canada's leading active cancer treatment and research centres located in downtown Toronto.

Plans to increase our bed size to 200 have created openings for permanent staff on our Chemotherapy and Radiotherapy in-patient units and applicants must be available for both 8 and 12 hour shifts.

We place strong emphasis on the psycho-social support aspect of nursing care and seek nurses with a desire to learn and practise these skills.

If you are interested in specialized nursing in a cancer treatment centre, please submit your resume to:

Mrs. L. Mills  
Personnel Department  
Princess Margaret Hospital  
500 Sherbourne Street  
Toronto, Ontario  
M4X 1K9

1-416-924-0671 Ext. 211

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Address correspondence to:

*The Canadian Nurse*

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## Registered Nurses

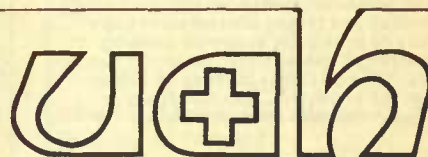
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# news briefs

News (continued from page 13)

## Did you know...

An Ohio company, Microcomputer Ventures Inc., has started paying health bonuses to its employees in an attempt to make it worthwhile for them to stay healthy. To qualify for the bonus, workers must exercise at least three days a week; running six miles a week qualifies an employee for a \$25 bonus while 14 miles a week earns \$35. Although the bonuses are not large they have provided the necessary encouragement to get workers exercising and already the company's employees have lost an average of 13 pounds each.

## Did you know...

Canadian researchers have found body weight to be the only risk factor associated with statistically significant differences in survival among 750 breast cancer patients. The Medical Post reports Dr. Norman Boyd of the Princess Margaret and Sunnybrook Hospitals in Toronto as saying that as far as he knows his study is the first to show an interaction between treatment and weight among breast cancer patients. This seems to hold true even if other factors including the severity of disease at admission are taken into account. The one exception to the finding was in premenopausal women aged between 40 and 45.

## Health happenings

The Canadian Council of Cardiovascular Nurses has issued a statement on their position on cardiopulmonary resuscitation (CPR). The CC of CN recommends that basic CPR be taught in all accredited schools of nursing, that basic CPR classes be available to all RN's, and that the ability to perform CPR be an employment prerequisite for nurses who are working in critical care areas or in occupational health.

A spokesman for the group at the Canadian Heart Foundation says that, contrary to popular belief, all nurses are *not* currently qualified to provide life support through CPR.

## Health happenings

An Indian Health Care Commission consisting of five Alberta natives has been set up in that province to oversee administration of existing health programs and to plan and implement new activities.

Federal contributions of up to \$2.5 million have been promised. Included in the plans are new alcohol treatment centers, a detoxification center, provision of health workers at Indian friendship centers in Edmonton and Calgary, and a nurses' training program.

## Did you know...

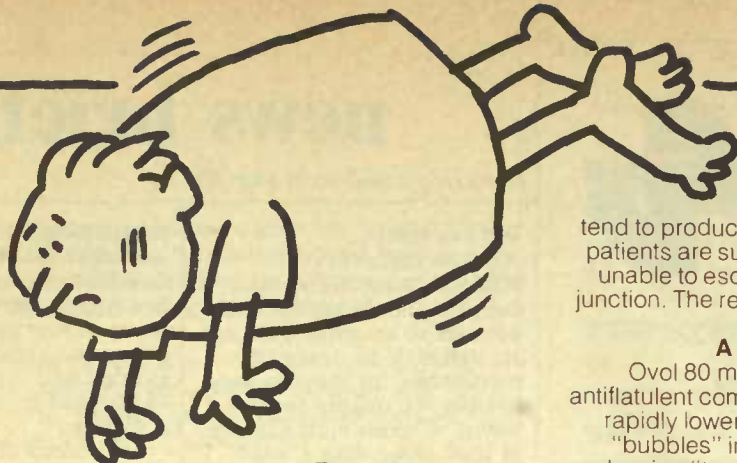
A new vaccine, considered a breakthrough in anti-rabies treatment, is now available. The Human Diploid Cell Vaccine (HDCV), which provides higher levels of protection than previously used vaccines, has shown no evidence of severe reactions and is more easily and less painfully administered. The new vaccine requires only six inoculations, four during the first two weeks, a booster on the 30th day and a final booster on the 60th day. Although the cost of HDCV is considerably higher, this difference may be offset by fewer physician visits.

## Did you know...

A drug, **Ibuprofen**, commonly called Motrin®, is being tested at the University of Western Ontario as a treatment for inflamed joints commonly suffered by hemophiliacs. Up until now, no single safe drug could reduce both the pain and inflammation caused by hemophilia. The most common anti-inflammatory drug — aspirin — cannot be used in hemophiliacs because it prolongs bleeding time. Typical aspirin substitutes such as acetaminophen can relieve such pain but not inflammation.

The investigators of Ibuprofen tested a single small dose in two groups of volunteer patients and found that it has only minimal effects on bleeding time in both normal and hemophilic subjects.





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### The problem: flatulence.

Although flatulence is normal to a certain degree, some conditions tend to produce, or exacerbate it. In particular, when patients are supine for lengthy periods, gas may be unable to escape through the oesophago-gastric junction. The result is distention, bloating, discomfort, borborygmi, and pain.

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Prescribing information on page 45

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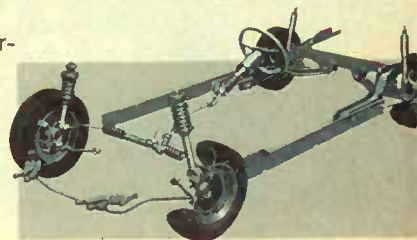
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6.7L/100 km

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